R E P O R T R E S U M E S

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FLORIDA "STATE" MIGRANT HEALTH PROJECT, ANNUAL PROGRESS REPORT 1964 - 1965.

FLORIDA STATE BOARD OF HEALTH, JACKSONVILLE

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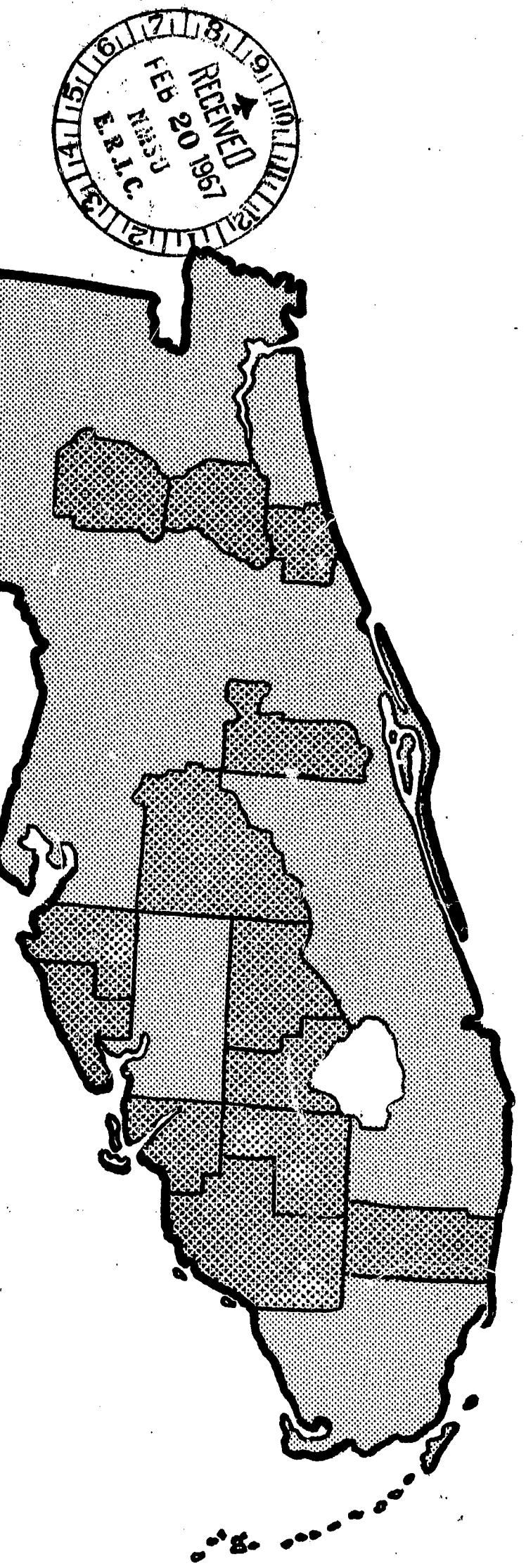
THE REPORT DISCUSSES THE HOUSING, HEALTH SERVICES, SANITATION, AND HEALTH EDUCATION PROGRAMS FOR MIGRANT AGRICULTURAL WORKERS IN FLORIDA. IT STATES THE OBJECTIVES OF EACH PROGRAM, PROGRAM ACCOMPLISHMENTS DURING THE YEAR, AND SUGGESTIONS FOR FUTURE PROGRAMS. (CL)

Florida

"STATE" MIGRANT HEALTH PROJECT



Annual Progress Report
1964 – 1965

FLORIDA STATE BOARD OF HEALTH

in cooperation with the

U.S. PUBLIC HEALTH SERVICE

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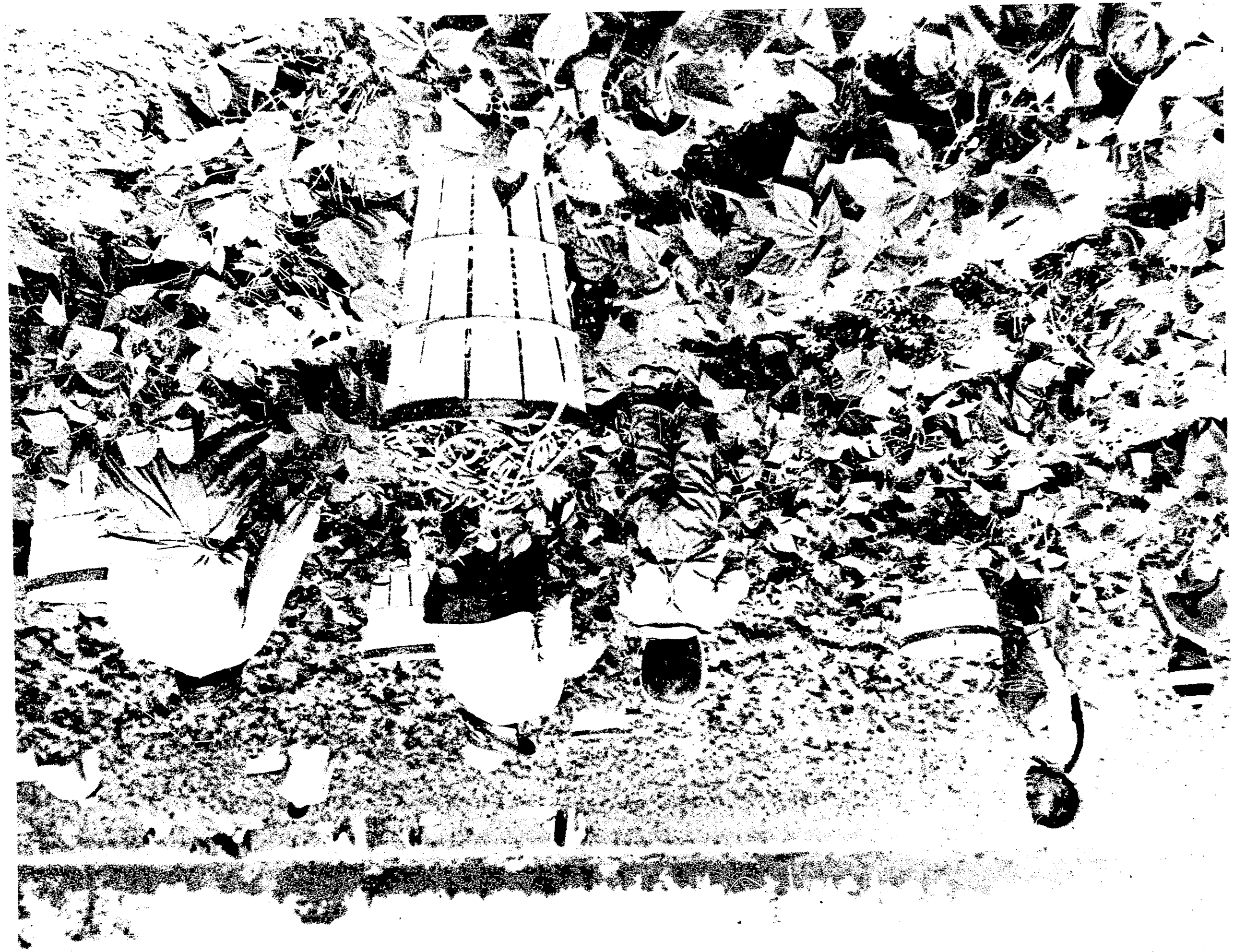
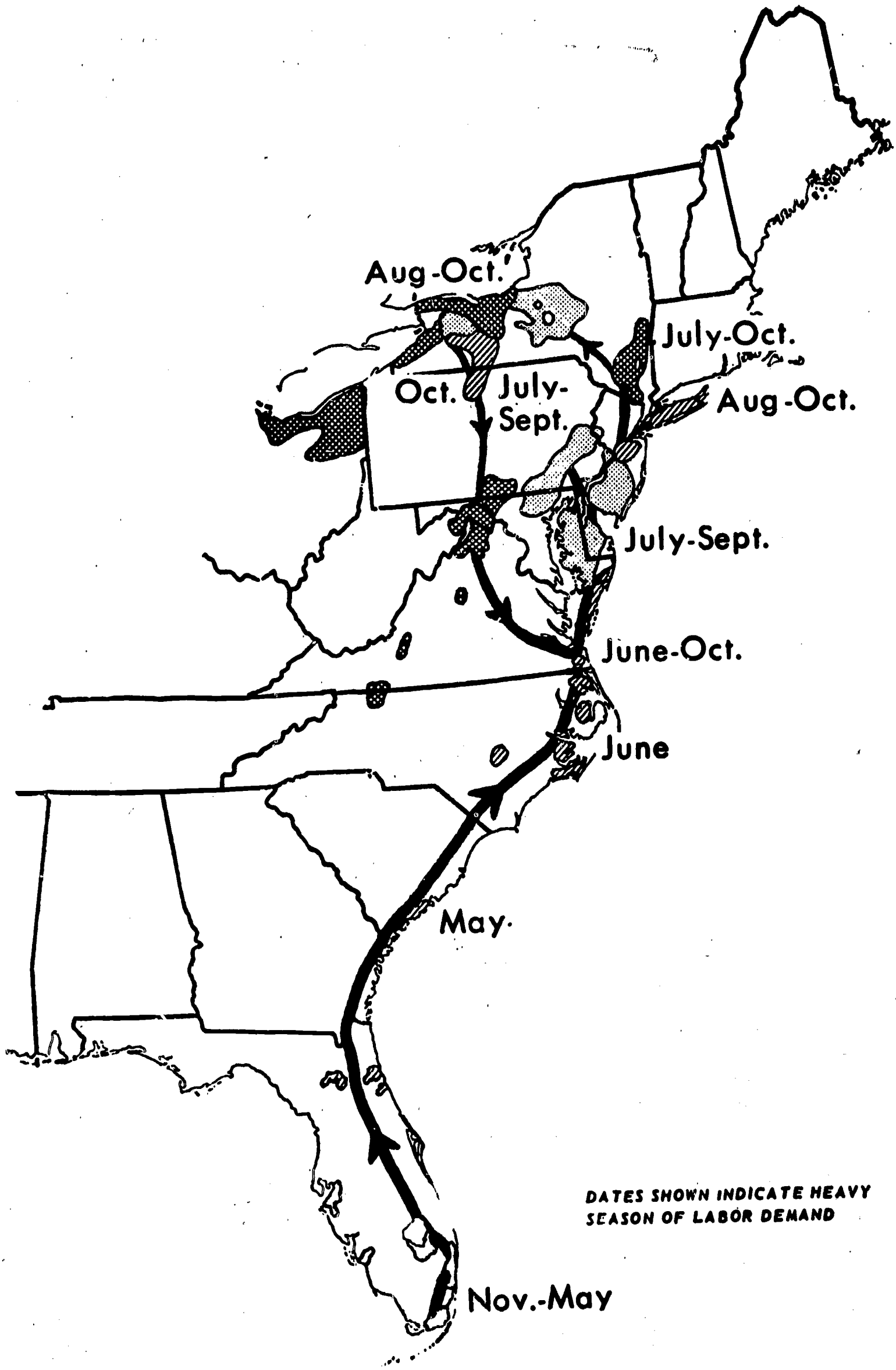
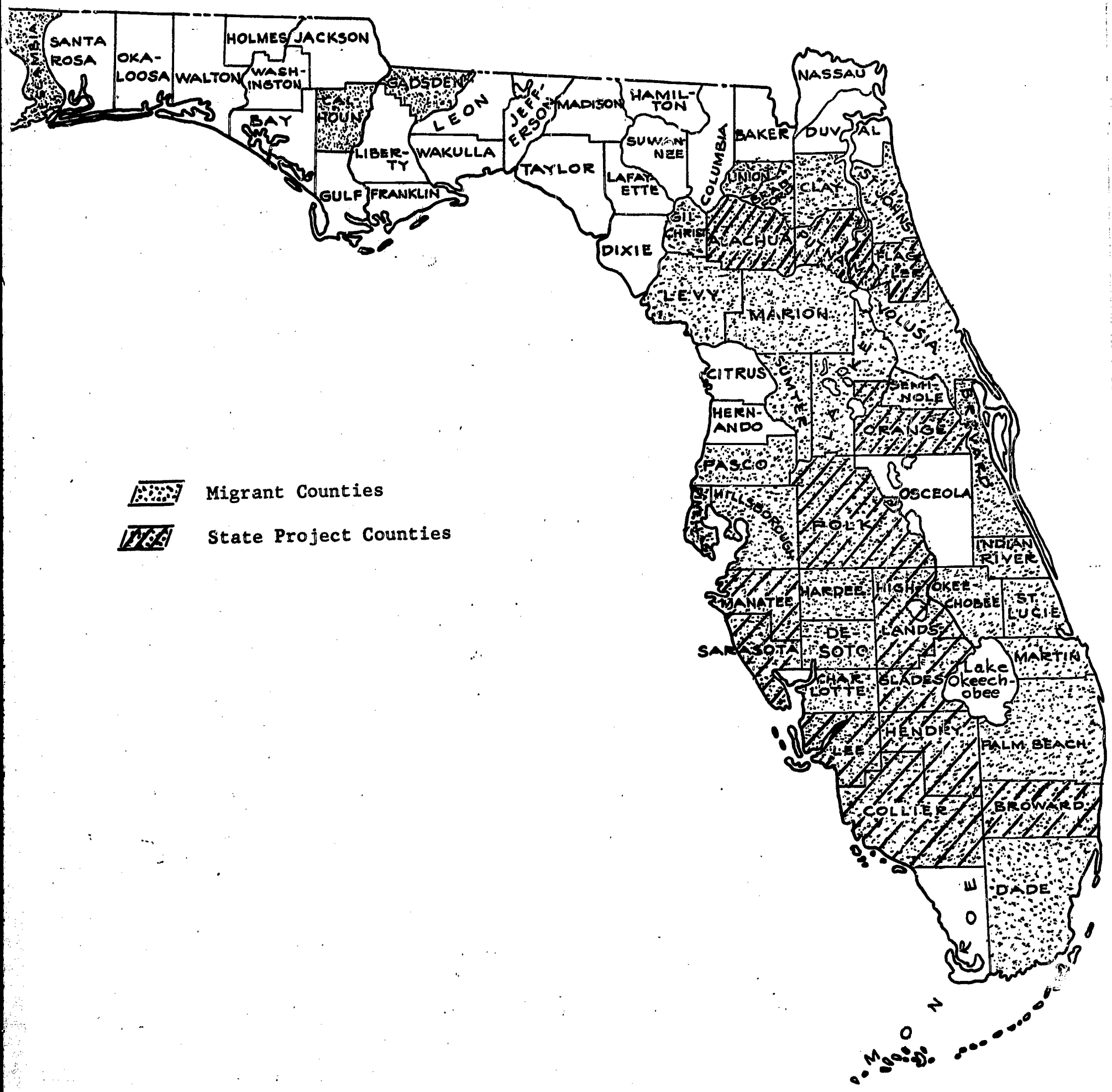




THE ATLANTIC COAST MIGRATORY STREAM.



Migrant Counties

State Project Counties

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FLORIDA STATE BOARD OF HEALTH

ANNUAL PROGRESS REPORT

MIGRANT HEALTH GRANT MG-18B R (65)

BACKGROUND

The following second Annual Report on the Florida "State" Migrant Health Project is hereby submitted as requested by the United States Public Health Service. This report covers migrant health activities engaged in by 13 participating counties for the period September 1, 1964 through May 31, 1965.

The Florida State Board of Health initially received a grant award from the U. S. Public Health Service in 1963 to inaugurate a migrant project entitled: "A project to develop a basic statewide program of health services for migrant farm workers and their dependents in Florida." This title was retained for the Project's second year. The first year's operation might be considered as a "planning" year during which information necessary to implement the following year's action program was gathered. The Project period for the first year extended from September 1, 1963 through August 31, 1964. The first Annual Report covered this twelve month period.

The U. S. Public Health Service approved Florida's Project Continuation Request and the second or "action" year of the Project started in September of 1964. Ten counties comprised the nucleus of the "State" Project during the first few months of the current year's operation, but a recent Project Revision made it possible for three additional counties to participate and to extend the Project period through the calendar year of 1965.

The Project is administered by the Bureau of Maternal and Child Health, David L. Crane, M.D., Director. The Migrant Health Coordinator is William J. Clarke, Jr. Present Project personnel include 2 Health Officers, 12 Public Health Nurses, 9 Sanitarians, 2 Health Educators, 1 Nutritionist, 4 Clerk-Typists, 1 Dental Assistant, 1 Clerk-Clinic Aide and 1 Equipment Operator.

MIGRANT SITUATION

Although each county that actively participated in the Project is written up individually in later pages of the Annual Report, we feel that certain additional information should be included in this particular section to give a broad view of the many facets of the migrant situation in Florida.

The Project counties not only represent the three areas of the State (i.e., northern, central and southern), but also the areas where the migrant concentration is greatest. The problems affecting migrants, growers and health departments may vary in magnitude from county to county, however, the basic problems besetting all three groups are real and present in all of the Project counties.

The Migrant Flow

Agricultural migratory workers have been utilized in Florida since the early 1920's. We estimate that our State hosts an average of 100,000 migrants annually and this year was no exception. This migrant force is composed of approximately 86 per cent domestic and 14 per cent offshore. Ethnic composition of the domestic is estimated as follows: Negro 63%; Texas-Mexican 11%; Puerto Rican 7%; and Anglo 5%. The offshore workers, all Negro males, are from the British West Indies and the Bahamas. The ethnic makeup of the migratory labor force varies from county to county depending upon crops grown, housing facilities available, previous migration patterns, community attitudes, contracts with crews, and growers preferences. Some of these same factors determine the use of offshore workers to some extent plus the element of availability of domestic laborers. The use of offshore labor in Florida is limited to the harvesting of citrus, sugar cane, celery, strawberries and trellis tomatoes. Domestic workers cannot be recruited in sufficient numbers to meet grower demands for the harvesting of these crops.

Florida is the base for the structure of the Atlantic Coast Migrant Stream. This "stream" of workers is activated in the late spring as the labor force moves up from the southern portion of the State through north Florida and on up through the Carolinas and Virginia into New York. A second "stream" smaller in numbers but gradually increasing, moves up from Florida to the North Central States of the country. With the coming of Fall, the process is reversed and the migrants re-enter our State in October and November. It was noted this year that a larger number of workers returned earlier than usual due to poor crops resulting from adverse weather north of

the "sunshine" State. It was gratifying to note this year that the recent trend continued for migrants to return earlier and leave later in order that their children might complete a full school year.

The balance between labor supply and demand was upset this year due primarily to unusual weather conditions and increased plantings. These two problems are discussed in later pages in more detail.

The number of Cuban refugees employed in agriculture increased, but their total percentage is still insignificant when compared with other ethnic groups. Although Cuban employees compose up to 95 per cent of the industrial working force in some sugar plants, few Cubans will accept physical labor in the fields. In the past years, a comparatively small number of these displaced persons were day-hauled from Miami to fields in Dade and Broward counties. This year, Cubans were also found scattered in migrant areas from Broward County up to Gadsden in north Florida.

Factors Influencing the Migrant Situation

In some respects, it might be said that this was an unusual year for agriculture in Florida. The weather was unseasonably warm and dry, resulting in crops maturing earlier and quite bountifully. This affected the scheduled appearance of crews and left some areas shorthanded for labor. It also resulted in more intrastate movement of migrants which affected clinic plans and continuity of health services for migrants. An interesting side effect of the weather was noted in the attitude of many citrus workers. The trees bore such quantities of fruit that many of the pickers refused to harvest from the inner part of the trees (which is more difficult work) and left the groves if the grower insisted they pick the entire tree.

A blight known as mosaic disease struck some watermelon producing areas of the State, especially Lee and Collier Counties, resulting in many migrants leaving these areas and the State earlier than usual.

Vegetables and citrus plantings and harvests increased in volume statewide which also strained the labor supply pool. Citrus planting in the southern counties of the State continued to grow this year, vying with vegetables in popularity among growers in some sections. The recent development of an orange tree with a shallow root system, safe from the high water table prevalent in south Florida, contributed to increased citrus

plantings as did improved drainage and planting techniques.

Mechanization appeared to have little new effect this year on the migrant situation, although growers' interest in mechanical harvesting devices was heightened by some labor shortages. Mechanical cutters were experimented with in some cane fields, but proved to be unsatisfactory compared to their human counterparts.

Because labor was in short supply during the past season, the growers' problems, due to this shortage, were many. People, some without previous experience in field and grove work, were transported to Florida at the growers' expense. Few stayed on the job for more than a few days. Some arrived too late on Friday to start work and had disappeared from the vicinity by Monday morning when the trucks or buses came by to pick them up to start work. It is interesting to speculate on how effective the present plans will be to recruit additional domestic labor for the coming season. One bright spot in the picture was the increase of wages paid in some areas as a consequence of the imbalance between labor demand and supply. It might be noted here that many growers prefer Tex-Mexicans to other domestics because they aver that this group is harder working and the crews are more stable. The Labor Department's decision to discontinue the use of Mexican Nationals in the country (effective December 31, 1964) may affect the influx next season of the Tex-Mexicans into Florida. The labor void created by the absence of many thousands of Braceros from western fields may be partially filled by those Tex-Mexicans who own homes in the west. These migrants have been working in Florida during the past several seasons. If this speculation does turn out to be valid, a further decrease in the available work force in Florida would ensue with its attendant problems.

Housing

During the eight or nine months that comprise the migrant season, Florida produces tons of practically any vegetable grown in any part of the United States. The citrus and sugar industries are also enterprises of mammoth pro-

portions which operate in full swing during the season. The migrant labor force, upon which our State's agriculture depends, is constantly in a state of flux, moving from place to place in pursuit of agricultural employment. During the course of their travels, they are housed in a variety of accomodations ranging from satisfactory to poor. This year was no exception as far as the range of housing was concerned, but we did have fewer inferior units operating than in previous years. This fact may be ascribed to more strict enforcement of the provisions of the Florida State Board of Health's Camp Regulations and the increase in sanitation personnel, under the aegis of the Project, to enforce these regulations.

The housing shortage for migrants which has plagued Florida for the last few years worsened this year. This shortage affected the movement of many workers by channeling late arrivals seeking housing in some sections into areas that had previously enjoyed either none or at most a sparse settlement of these people. The descent of the migrants upon some heretofore "virgin" territories was greeted by some of the resident population with something less than enthusiasm.

It was noted this year that the concentrations of migrants in the lower income areas of towns and cities tended to increase and the camp populations decreased. This trend began a few years ago and has caused concern on the part of public health officials on several counts. Many public health people contend that when migrants move into "depressed" urban areas they become more difficult to identify. They aggravate the overcrowded conditions already existing in the areas with a resultant increase in disease potential. Their cultural patterns often bring them into conflict with the established residents and they add to the workload of any understaffed health department that is charged with maintaining a healthful environment.

The migrants continued this year another trend of recent vintage, purchase of small pieces of property in or near urban areas. They usually pay a modest monthly payment on the lot and build small houses or move in trailers, the latter invariably being in various stages of dilapidation. During the

summer months these are either locked up or occupied by the nonworking members of the family while the others migrate.

A new wrinkle has been added to the migrant housing picture recently with the advent of the speculator. This individual will purchase a piece of property, divide it up into small lots, construct houses on the lots and ostensibly sell the house on monthly payments to the migrant. This is an advantageous arrangement for the speculator as he is collecting a monthly fee year round for the houses, but is free of the regulations of the State Board of Health's Camp Law and also the rental regulations and license fees of the State Hotel and Restaurant Commission. Due to the migrant's way of life, which is fraught with uncertainty, he has less chance of completing the purchase of the house than any segment of our population. This causes little concern to the speculator, for he can always find a replacement for the migrant he evicts.

In some counties this year, enforcement of the Camp Law was relaxed due to the shortage of available housing. The health department personnel felt that inferior housing was better than no housing at all, especially in areas where quarters were overflowing with migrants and many of them were sleeping in and under cars, trucks and buses. This was the final year of operation for the last known migrant tent camp in the State, although it was proposed in one Project county during this season that a tent camp would be the answer to their housing shortage.

Because so many of the migrants spend only a short time in some counties, often as little as three weeks, the growers who furnish housing are understandably reluctant to invest in the better type housing, especially when so many of their tenants tend to be rather destructive.

Many of the Florida counties that depend on agriculture are searching for a solution to the housing shortage. Few of them feel that they can afford to construct the needed facilities and believe that the State or Federal Government should shoulder this responsibility. Some county officials this

year indicated interest in investigating the possibility of obtaining Federal loans for migrant housing construction and indications point to something being accomplished in this direction in the near future. A few groups of growers in Project counties have similarly expressed interest in obtaining Federal funds for housing, some of them even going so far as to have plans drawn of proposed camps, but to date, no federally-financed construction has been initiated in Project counties. The new migrant housing which was erected in the thirteen counties this year, was built with private capital.

Sanitarians in Project counties reported this year that several factors hampered their effectiveness. The language barrier and lack of literacy prevented them from conveying their instructions to some migrants. Apathy on the part of the migrants was considered a hindrance to improving conditions in housing areas. Absentee landlords delayed the progress of needed repairs and renovations in housing, due to their unavailability for contact. Many units that were condemned as unfit for human habitation were reoccupied by the evicted migrants soon after the sanitarian left the premises.

Nursing and Medical Services

There was a significant increase this year in the number of migrants receiving nursing and medical services, especially in some Project counties. This may be attributed to increased nursing and physician personnel being available, under Project auspices, to render services. Some counties inaugurated evening clinics to accommodate the target population that spends the daylight hours in the fields, groves, and packing houses. The number of migrants served would have been greater if some of the counties, such as Manatee, Sarasota, and Putnam, had been able to employ needed personnel before the migrants had begun their northward trek. In fact, only one county, Collier, actually filled its nursing position during the initial month of this Report year. There was a turnover in Project personnel during the year which also hindered the full effectiveness of the program, due to difficulty encountered in filling the resultant vacancies.

The Project seemed to act as a catalyst in that various health department disciplines increased their interest in migrant services. Some of the nurses began taking Spanish courses this year to overcome the language barrier. Demonstration items were acquired (without the use of Project funds) as devices to instruct the migrants. It seemed that the longer the Project operated, the more the various county health departments realized that there was a great deal about the migrants that they did not know, but should learn. The development of new techniques to reach the migrants plus increased personnel bore fruit this year and should continue to prosper when the workers return in the Fall.

It is probable that more migrants would have been served if they had some means of transportation. A small bus was used in Collier County for this purpose, and in Hendry County a crewleader's mother was reimbursed for trips made to clinics with patients. Some residents volunteered to bring patients to the health departments or to physicians' offices, but these Good Samaritans were rather few in number. Many individuals who were approached to serve as volunteer drivers declined on the grounds that they would be liable if an accident occurred while they were transporting the migrants to or from clinics. Some growers brought workers in to health departments, but this was an infrequent event. A sprinkling of the more enlightened migrants, including some pregnant women, walked or "thumbed" their way for several miles to clinic locations.

It is well known to health department directors and nurses that most migrants who become ill do not seek medical service until their ailment has progressed to the point where they are unable to work. Several reasons account for this phenomenon, one of them being the inability of the migrants to pay for a visit to a doctor or pay for medicines prescribed. In those Project counties which utilized private physicians on a fee-for-service basis or reimbursed them for operating migrant clinics, many workers and their dependents received treatment which forestalled their being confined to hospital beds. In one county alone (Collier) the Project can be credited with saving the lives of at least ten migrant children this year.

In a few of the participating counties, the medical society refused to cooperate with the program as far as sanctioning the fee-for-service or clinician setups for their members were concerned. Some physicians in these counties treat migrants, although they realize that there is little likelihood that their fees will be paid. A physician in Lee County donates a half day each week to operating a clinic for Spanish speaking migrants. This year, he treated 466 migrant patients in the clinic. In Highlands, Hendry, and Glades Counties, the migrants referred to private physicians are especially encouraged to pay at least part of the bills that they incur. A few of them do pay a portion of their expense.

The dental care of migrants has not received as much attention as it merits. The teeth of the domestic migrants are ordinarily in poor condition. A few Project counties have arranged for private dentists to do dental work for migrants, mostly on an emergency basis, for a reduced fee. Dentists are reimbursed from Project funds. Some of the health departments have dental preceptors who care for school children in the lower elementary grades, many of whom are migrants.

In some Project counties where a reduced fee schedule was worked out with the local hospitals for the use of emergency rooms, there was also a reduction in the number of cases admitted for inpatient care with a consequent decrease in red ink bills for migrant hospitalization.

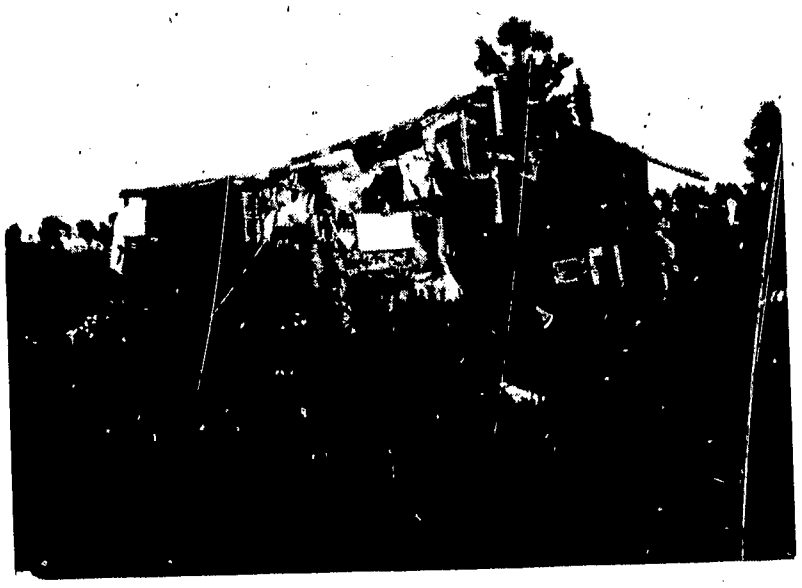
The movement of migrants from camps in rural areas to urban areas, discussed in preceding pages, created a problem for health department personnel. Because of the temporary assimilation of many of the migrants into the resident population, it was difficult for clinic clerks and nurses to differentiate between migrants and indigent residents when it came to rendering service. Because migrant funds are to be used for migrant services, it is incumbent on the health department staff to separate migrants from non-migrants. This was

a minor problem in areas where most of the people who come to the clinic facilities are known to the personnel, but it proved to be a major problem in clinics in the larger urban areas. This problem has been partially solved by lengthy questioning of the patient (more lengthy if a language barrier exists) but it still is a time consuming task. If all migrants carried the PHS 3562 Record, it would speed up the rendering of actual service, save time and frustration for personnel and increase the validity of identification. It was found this year that a comparatively small percentage of the migrant population carried these records.

Because health departments recognized that the necessity for having adequate records and forms was vital to the efficient operation of the clinics, several of the health departments devised their own forms. Before the migrants return this autumn, recommendations made by health departments will be incorporated into the development of new Project forms. This will provide uniformity in record keeping, thus ensuring more comprehensive data on which to base next year's Annual Report.

One salient feature of Florida's health services for migrants this year was the implementation of the Health Service Index and Referral Form System.

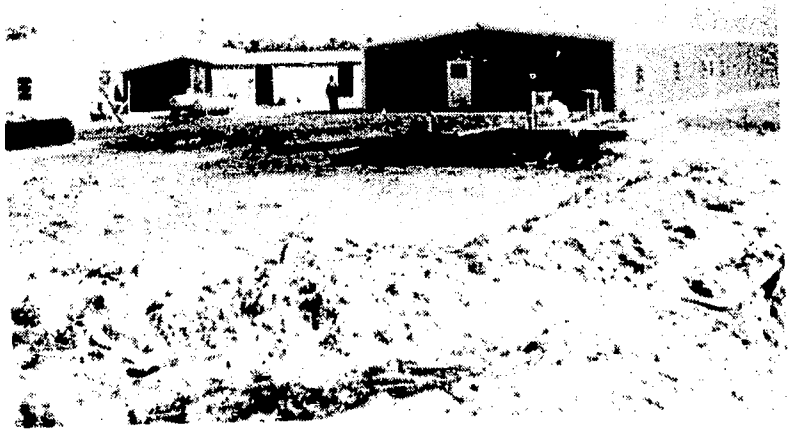
The System, developed during the planning stage of the Project, is designed to provide continuity of health care services for migrants as they move from place to place. We believe that the Referral System, already considered to be an integral part of our migrant health service in the Project counties, will eventually be accepted throughout the country as the answer to the problem of health care continuity for the target population. Because of our faith in the value of the System and the interest in it expressed by many states, the following section of this Report is devoted to a review of the System's efficiency to date based on nearly two hundred referrals made this year. Additional information may be found under Objective 7 of the section Project Objectives of this Annual Report.



Tar-paper shacks spring up overnight when some migrants purchase lots. It takes much longer for the sanitarian to have them removed.

A host of discarded school buses are used by migrants for transportation. Legislation is pending to regulate intrastate migrant transporation in Florida.

One of the many condemned camps in Florida. Migrants frequently move back in after tearing off "condemned" signs.



New camp for domestics in Collier County. Note sewage treatment plant in foreground. Overall migrant housing picture in Florida is improving but it takes time.

Many children in this Immokalee classroom are migrants. Probably few will ever graduate from high school or break out of the migrant stream.

One of the day care centers in Florida operated by the Florida Christian Ministry to migrants. Many more such centers are needed in the State.

This machinery shown in a celery field speeds up the harvesting procedure. Technology will never displace the need for migrants in many of Florida's crops.

FLORIDA STATE EMPLOYMENT SERVICE

FLORIDA FARM LABOR BULLETIN

FLORIDA INDUSTRIAL COMMISSION, TALLAHASSEE, FLORIDA, TELEPHONE: 224-9121
J. D. WRIGHT, JR., CHAIRMAN

VOLUME 10, NO. 26 APRIL 12,1965

SOUTH FLORIDA SUMMARY — ADDITIONAL WORKERS NEEDED IN MANY CROP ACTIVITIES DUE TO UNSEASONABLY WARM WEATHER CONDITIONS. All crops are showing rapid maturity. Labor demands reported active in Dade County lime harvest and Lake Okeechobee sugar cane cultivation.

BELLE GLADE — CORN HARVEST INCREASING RAPIDLY, ACCENTUATING SHORTAGE IN CELERY AND SUGAR CANE. Unseasonably warm weather continues to hasten maturity of crops. Workers also needed in sugar cane cultivation and celery cutting.

DELRAY BEACH-POMPANO — LABOR SITUATION VERY TIGHT. Workers returning to surrounding areas as their harvest activities are picking up. Bean harvest active.

FORT MYERS-IMMOKALEE — LABOR SHORTAGES LIMITED TO INDIVIDUAL WORKERS AS CREW FILL-INS. Housing becoming a limiting factor. Crops maturing rapidly under very warm weather conditions.

PRINCETON-HOMESTEAD — ADDITIONAL WORKERS NEEDED IN TROPICAL FRUIT AND MIXED VEGETABLES. Fifty lime pickers needed now. Remaining vegetable crops maturing rapidly.

CENTRAL FLORIDA SUMMARY — VALENCIA CROP NOW PASSING MATURITY RATIOS IN VOLUME. Most areas report need for individual workers as crew fill-ins. Dry weather conditions has brought on increased demands for additional irrigation workers.

BRADENTON — SHORTAGE OF HOUSING CAUSING SERIOUS PROBLEM FOR USE OF ADDITIONAL MIGRANT CREWS. Labor supply and demand in balance at present.

COCOA — LABOR SUPPLY ADEQUATE FOR CURRENT VALENCIA AND GRAPEFRUIT HARVEST. Market conditions very good.

FORT PIERCE — INDIVIDUAL CITRUS PICKERS NEEDED AS CREW FILL-INS. Sugar cane cultivation active. Vegetable harvest expected to pick up by next week.

LEESBURG — CITRUS HARVEST INCREASING. Additional crew replacements needed. Vegetable and watermelon pre-harvest work active.

Copies of this bulletin giving crop and labor information are sent out weekly during the season to all interested persons.

A GUIDE TO *Florida* CROPS

THIS BULLETIN CONTAINS INFORMATION REGARDING:

Location of Harvest Areas

Crops to be Harvested

Time of Harvest

General Working Conditions and Pay Rates

Routes to be Followed

FLORIDA CROPS INCLUDE:

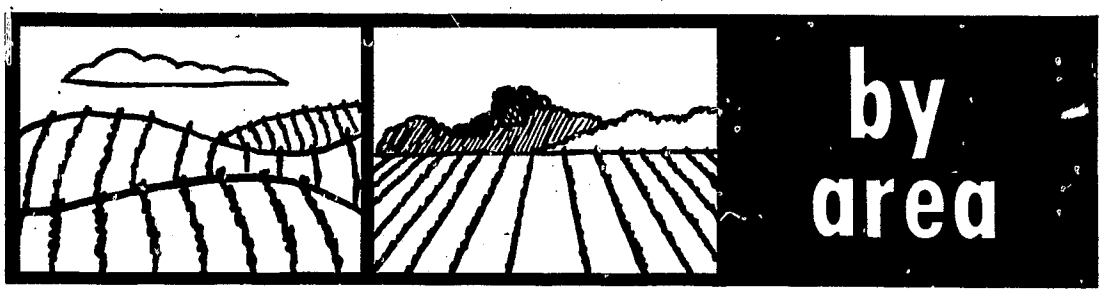
Citrus and Tropical Fruits

Vegetables

Sugar Cane

Tobacco

Peanuts



FARM LABOR DEPARTMENT
FLORIDA STATE EMPLOYMENT SERVICE
FLORIDA INDUSTRIAL COMMISSION

REVISED 9-1-59

GENERAL INFORMATION

FLORIDA FRUIT AND VEGETABLE HARVEST

1. Location of Work in Florida	See Seasonal Chart and Map.
2. Type of Labor Required	Single men and family units with agricultural experience.
3. Age and Physical Condition	18-60. All workers must be physically fit, free from chronic ailments, and willing and able to perform manual labor.
4. Length of Employment	See Seasonal Chart.
5. Work Hours	8 to 10 hours per day.
6. Wages	Prevailing wages in areas where employed. Specific information will be given at time of recruitment.
7. Housing	Public and private, ranging from $2.00 to $3.50 per person per week. Many employers have private housing facilities which are furnished to the worker free of charge or at nominal cost. Generally, worker must furnish bed linens, blankets, cooking utensils and dishes. Lights and water are furnished usually. Specific information as to type of housing available and equipment necessary will be given at time of recruitment.
8. Pay Period	Pay period, depending on type of crop and employer, ranges from daily to weekly. Specific pay information will be given at time of recruitment.
9. Type of Work	Harvesting crops, which consists principally in picking tomatoes and beans; cutting cabbage, celery and sugar cane; picking up potatoes and harvesting miscellaneous vegetable crops including strawberries and watermelons; and picking oranges, grapefruit and other citrus and tropical fruits.
10. Recruitment	Information regarding job openings can be obtained by contacting local State Employment offices. Workers will be assigned direct to growers rather than pools.
11. Transportation	Terms of transportation will be arranged at the time of recruitment. (Transportation furnished from camp site to job.)
12. Climate	Average temperature during harvest season is 70 degrees. Light summer clothing can be worn throughout most of the season. However, there will be days in which coats or jackets should be worn due to cool weather. Other protective clothing not needed.
13. Schools, churches and Recreation	Schools and church facilities are available to seasonal agricultural workers and families the same as to local residents. School bus transportation is provided in all areas. Good fishing in all the agricultural areas. No license required for cane pole fishing. Other recreation available.

HERE IS YOUR INFORMATION

THIS PAGE CONTAINS INFORMATION ON LOCATION OF STATE EMPLOYMENT SERVICE OFFICES··· LOCATION OF HARVEST AREAS··· CROPS TO BE HARVESTED··· TIME OF HARVEST··· HIGHWAYS TO FOLLOW···

SEVEN TIPS TO WORKERS

1. **DON'T** go where you are not needed.
   Ask your local State Employment Office.

2. **DON'T** go too soon.
   Ask your local State Employment Office.

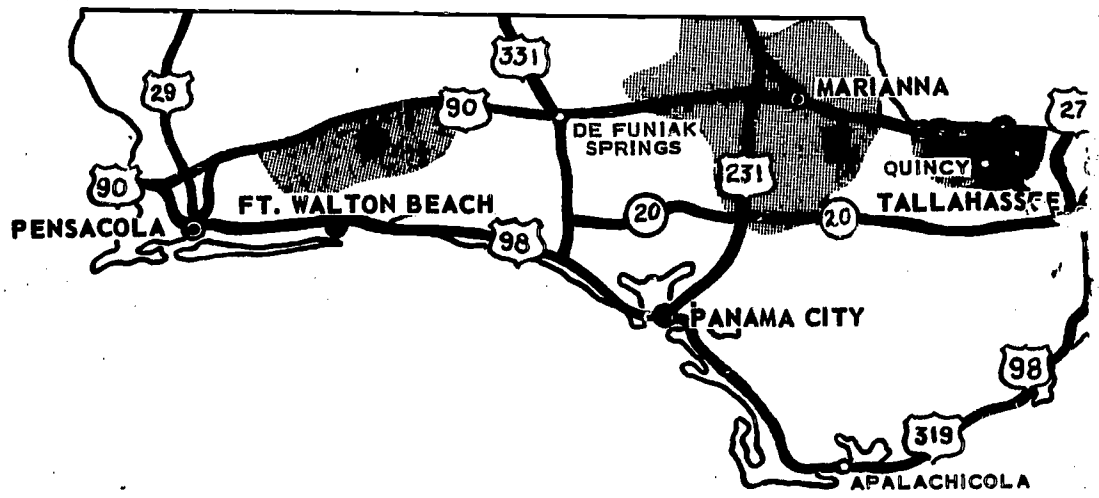
3. **DON'T** leave home without a job prospect.
   Ask your local State Employment Office.

4. **DON'T** go where there is no available housing.
   Ask your local State Employment Office.

5. **DON'T** leave home without definite understanding about work and wages.
   Ask your local State Employment Office.

6. **DON'T** leave home before carefully planning your trip.
   Ask your local State Employment Office.

7. **DON'T BELIEVE RUMORS** regarding jobs and pay.
   Ask your local State Employment Office.



SEASONAL CHART

		JUL.	AUG.	SEP.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY.	JUN.
A	POTATOES												
	WATERMELONS - TOBACCO												
	MIXED VEGETABLES												
B	POTATOES												
	CABBAGE												
C	CITRUS												
	TOMATOES												
	MIXED VEGETABLES												
D-1&D-2	TOBACCO (SHADE) D - 2												
	TOBACCO (BRIGHT LEAF) D - 1												
E	PEANUTS												
	COTTON												
	TUNG NUTS												
F	CITRUS												
	MISC. VEGETABLES												
G	CITRUS												
H	CELERY												
	CITRUS												
	MISC. VEGETABLES												
	CORN												
	TOMATOES												
I	SUGAR CANE												
J	POTATOES												
	BEANS												
	CELERY												
	LEAF VEGETABLES												
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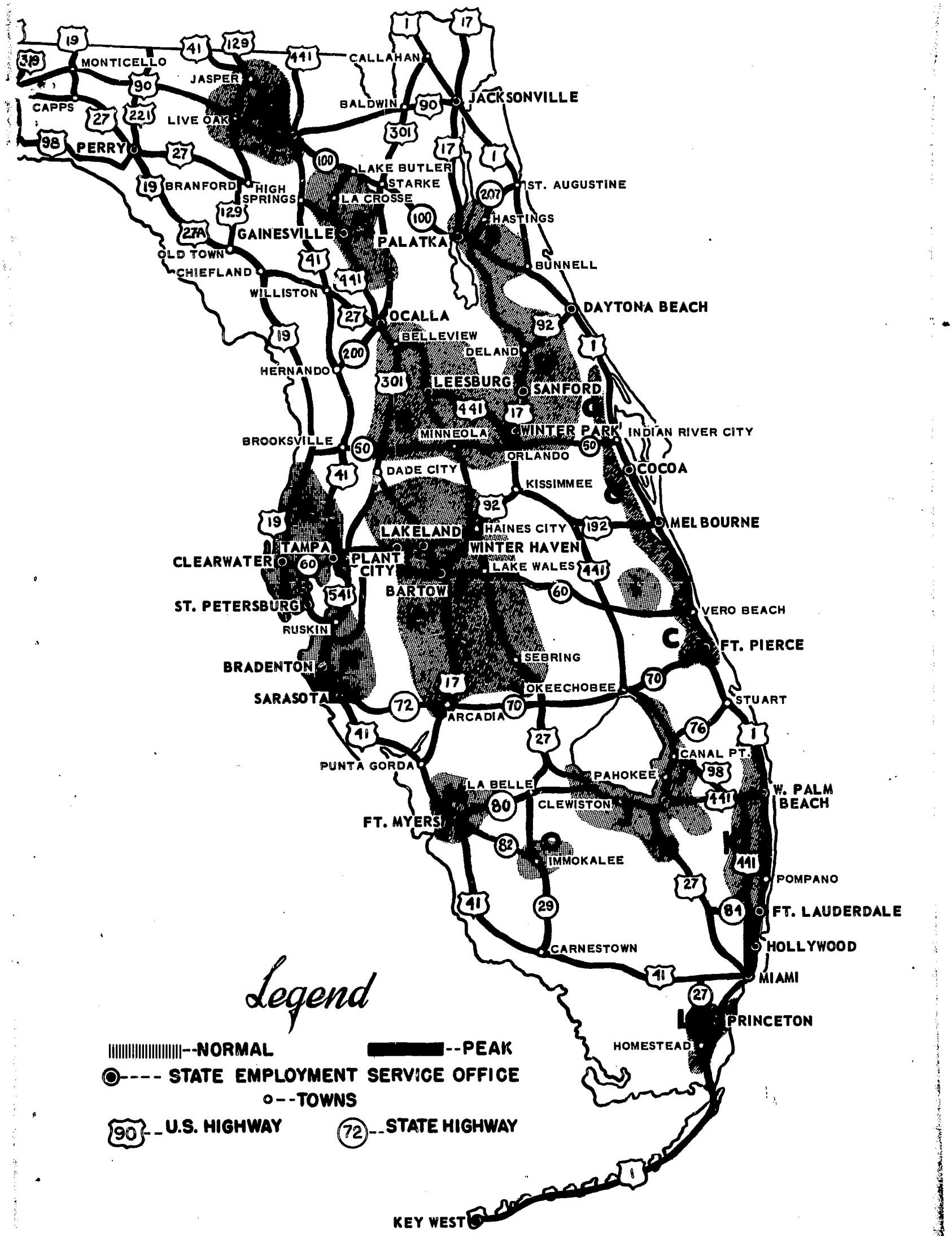
	POTATOES												
	BEANS												
	MIXED VEGETABLES												
M	POTATOES												
	MISC. VEGETABLES												
N	TOMATOES												
	CELERY												
	MISC. VEGETABLES												
	SWEET CORN												
O	TOMATOES												
	CUCUMBERS												
	MIXED VEGETABLES												
	WATERMELONS												
P	COTTON												
	PEANUTS												
	POTATOES												


MONTICELLO
JASPER
CAPPS
LIVE OAK
PERRY
BRANFORD
HIGH SPRINGS
GAINESVILLE
OLD TOWN
CHIEFLAND
WILLISTON
CALLAHAN
BALDWIN
JACKSONVILLE
LAKE BUTLER
STARKE
LA CROSSE
PALATKA
ST. AUGUSTINE
HASTINGS
BUNNELL
DAYTONA BEACH
OCALLA
BELLEVIEW
DELAND
HERNANDO
LEESBURG
SANFORD
MINNEOLA
WINTER PARK
INDIAN RIVER CITY
BROOKSVILLE
ORLANDO
COCOA
DADE CITY
KISSIMMEE
MELBOURNE
LAKELAND
HAINES CITY
TAMPA
WINTER HAVEN
CLEARWATER
PLANT CITY
LAKE WALES
BARTOW
ST. PETERSBURG
VERO BEACH
RUSKIN
FT. PIERCE
SEBRING
BRADENTON
OKEECHOBEE
SARASOTA
ARCADIA
STUART
CANAL PT.
PUNTA GORDA
PAHOKEE
LA BELLE
W. PALM BEACH
CLEWISTON
FT. MYERS
IMMOKALEE
POMPANO
FT. LAUDERDALE
CARNESTOWN
HOLLYWOOD
MIAMI
PRINCETON
HOMESTEAD
KEY WEST
Legend
--NORMAL
--PEAK
STATE EMPLOYMENT SERVICE OFFICE
--TOWNS
U.S. HIGHWAY
STATE HIGHWAY

DESCRIPTION OF MAIN HARVEST CROPS

I. BEANS

A. The bean picker usually starts his employment in November and continues through May. Harvest is continuous throughout this period with favorable weather.

B. The bean picker harvests the different varieties of "snap" beans and places them in hampers. A hamper holds 32 pounds when full. The picker must have the judgment to pick the mature beans and leave the younger beans for later picking. He must exercise care in the handling of the bean plants, because damaged plants mean lesser earnings later on in the harvest.

C. Crawling, crouching, stooping, walking, and kneeling are the physical demands of the bean picker. He works in the open and in the sun. The work day is from 7 to 8 hours, frequently delayed until 9:00 to 10:00 A. M. on account of dew.

D. The wages are based on piece work, and normally range from 50¢ to 75¢ per hamper. The whole season will average about 50¢ to 65¢ per hamper. Therefore, the earnings are contingent on the worker's willingness and ability to work. Some workers have picked as high as 24 hampers per day. A good worker should pick from 12 to 16 hampers per day. This, of course, depends on the weather and the yield.

II. TOMATOES

A. The tomato picker usually starts his employment in October and continues through May. Harvest is continuous throughout this period with favorable weather.

B. The tomato picker harvests the different varieties of tomatoes and places them in buckets. The picker must follow instructions as to picking of tomatoes ready for harvest, leaving the immature tomatoes for late picking. He must exercise care in the handling of vines to protect later harvests.

C. Works in stooping position. Works in the open and in the sun. The work day is from 8 to 10 hours.

D. Wages are based on both day and piece rate depending on market conditions and location of harvest area. Piece work pay-ranges from 8¢ to 10¢ per bucket. A good worker should pick from 80 to 100 buckets per day, depending on the weather and yield. Day rate ranges from $5.50 to $7.00.

III. POTATOES

A. The potato digger usually starts his employment in November and continues through May. Harvest is not continuous as indicated on seasonal chart.

B. The potato digger picks potatoes and places them in field crates or sacks. These crates hold approximately sixty pounds. The potato digger must exercise care not to leave potatoes in the rows.

C. Works in kneeling position and progresses along the rows by crawling. Works in open and in the sun. Work day is from 8 to 10 hours.

D. Wages are based on piece work and normally range from 5¢ to 7¢ per field crate. A good worker should pick from, 75 to 150 field crates or sacks per day. Workers on potato harvesting machines earn 75¢ to $1.00 per hour.

IV. SWEET CORN

A. Corn harvest is from December through mid-June. Harvest is continuous throughout this period.

B. The corn harvest is accomplished by two operations of pulling and grading. The corn puller picks corn and places it in tractor-drawn carts. The puller must exer-

cise care in picking mature corn only. The grader selects and packs corn by size in shipping crates in the field. Usually men are used as pullers and women as graders.

C. There are no unusual physical demands required in these jobs. Works in the open and in the sun. The work day is from 8 to 9 hours.

D. Wages are based mainly on day work and normally range from $6.00 to $7.00 for pullers and from $5.00 to $6.00 for graders. Piece rates average 6¢ per crate for pulling and 5¢ to 6¢ per crate for packing.

V. CITRUS

A. The citrus picker usually starts his employment in October and continues through May. Harvest is continuous throughout this period.

B. The citrus picker harvests oranges, grapefruit and/or tangerines from trees from ground level or by working from ladders placed against trees. Removes fruit by hand picking or hand clipping and places fruit into picking bag. When full, bags are emptied into field boxes.

C. Walking, reaching and climbing are the physical demands of the citrus picker. Works in the open and in the sun. Should have sense of balance. The work day is from 8 to 10 hours.

D. The wages are based intirely on piece work. Rates are from 17¢ to 25¢ per field box for oranges; from 10¢ to 15¢ per field box for grapefruit; and from 35¢ to 75¢ per field box for tangerines, depending on quantity of fruit in groves to be harvested. An average worker will earn from $10.00 to $12.00 per day.

VI. CELERY-

A. Harvest of celery is from December through mid-June, and is continuous during this period.

B. Celery is harvested by field machines, each machine requiring between 60 and 95 workers. The celery is cut by hand and placed on conveyor belts which carry it through washing vats for cleaning and then to packers who grade, and pack it in crates. After being packed it is loaded on trucks for delievery to local packing houses for pre-cooling, selling, and shipping.

C. Celery cutters are required to do considerable crawling and kneeling on very damp soil. Work is in the open and in the sun. The work day is 8 to 10 hours. Others working on machine harvesting celery also work from 8 to 10 hours per day under damp conditions and must stand in one position for long periods of time.

D. Wages for cutters are based on the row and usually average from $7.00 to $8.00 per day. Packers and others also average $7.00 to $8.00 per day.

VII. SUGARCANE

A. Sugarcane harvest is from October through May and is continuous throughout this period.

B. Harvesting sugarcane is done by cutting cane stalk at base by hand with knife, pulling side leaves from stalks, cutting leaves with blade, and placeing stalks in pile.

C. Harvesting sugarcane requires hard physical labor, including walking and stooping and working out in open in the sun. The work day is from 8 to 10 hours per day.

D. Wages are based both on day and piece work and normally range from $6.00 to $8.00 per day.

FLORIDA STATE EMPLOYMENT SERVICE OFFICES

LOCAL OFFICE	ADDRESS	TELEPHONE
Belle Glade	41 S. E. Avenue D	Wyman 6-3067-3068
Bradenton	401 Eighth St. West	4-0751
Clearwater	411-413 South Garden Avenue	3-1005
Cocoa	211 Willard Street	Newton 6-5511
Daytona Beach	146 Orange Avenue	Clinton 2-8546
Ft. Lauderdale	400 N. Andrews	Jackson 4-8641
Ft. Myers	1611 Jackson Street	Edison 4-1139
Ft. Pierce	411 Avenue A	Howard 1-6199
Ft. Walton Beach	41 East Main Street	Cherry 2-9090
Gainesville	413 S. W. Second Avenue	Franklin 2-4355
Hollywood	2406 Hollywood Boulevard	Wabash 2-1591
Jacksonville	40 East Bay Street	Elgin 6-3031
Key West	314 Simonton Street	Cypress 6-8512
Lake City	Old City Hall	765
Lakeland	515 East Lemon Street	Mutual 2-7116
Leesburg	206 North Third Street	State 7-2213
Marianna	208 Lafayette Street	Hudson 2-4300
Melbourne	345 New Haven Avenue	Parkway 3-0641
Miami	507-509 N. E. First Avenue	Franklin 4-5392
Ocala	409 S. Magnolia Street	Marion 2-4291,
Palatka	225 N. Second Street	East 5-5361
Panama City	1139 Harrison Avenue	Poplar 3-5012
Pensacola	236 West Garden Street	Hemlock 2-7655
Perry	112 West Green Street	399
Princeton	Federal Highway	Circle 7-8323
St. Petersburg	1004 First Avenue, North	5-5181
Sanford	110 West Second Street	Fairfax 2-3852
Sarasota	1411 State Street	Ringling 6-0158
Tallahassee	214 North Duval Street	3-4685
Tampa	315 Jackson Street	2-9341
West Palm Beach	907-9 North Dixie Highway	Temple 3-8464
Winter Haven	334 N. W. Third Street	Cypress 4-3113
Winter Park	State Office Building	Midway 4-1441

A REVIEW OF 179 MIGRANT HEALTH SERVICE REFERRALS

The major purpose of this review is to determine the extent to which health services to migrant farm workers resulted by means of the Health Service Index Referral System initiated by the Florida State Board of Health, Bureau of Maternal and Child Health. Secondarily, population characteristics, types of services requested and rendered, sources and destinations of referrals are among other data presented.

The number of referrals (179) may or may not represent the total number of referrals initiated under the referral system as of June 14, 1965. However, this represents the total known to the Florida State Board of Health.

Sources of Referrals: Table 1 shows the states and counties in which the referrals originated.

Table 1

Distribution of Referrals by State and County of Origin

STATE	COUNTY	NUMBER OF REFERRALS	PERCENT OF TOTAL
		179	99.9
Florida	Broward	1	.6
	Collier	8	4.4
	Dade	44	24.6
	Hendry	33	18.4
	Lee	3	1.7
	Manatee	1	.6
	Palm Beach	8	4.4
No. Carolina (11)	Henderson	11	6.1
Ohio	Darke	1	.6
	Lucas	7	3.9
	Putnam	12	6.7
	Sandusky	1	.6
Virginia (31)	Accomack	8	4.4
	Northampton	23	12.9

Destination of Referrals: Referrals were received by 16 Florida Counties in addition to counties in New Jersey, New York, Texas and Virginia. Tables 2 and 3 on pages 13 and 14 show the distribution.

Disposition of Referrals: For purposes of analysis, three categories have been established regarding completion of services requested by the referral: Partial means that partial service was rendered, i.e., not all service requests were fully met; Complete, meaning that service requests were fully met; None, meaning that no direct service was rendered in terms of the service request.

Results are shown here:

Table 4

Disposition of 179 Migrant Health Service Referrals

CATEGORY	NUMBER	PERCENT
Total	179	100.0
Partial	46	25.7
Complete	66	36.9
None	66	36.9
Not Reported	1	.5

Distinctions between Partial and Complete were often found to be subjective and judgmental; however, some services resulted from 112 (62.6%) of the referrals.

Table 2
Disposition of Migrant Health Service Referrals Made to
Selected Florida County Health Departments

County	Key Town	Total Referrals Received	Disposition			
			Complete Service	Partial Service	No Service	No Evaluation
TOTAL		165	62 (37.5%)	41 (24.8%)	61 (36.9%)	1 (.8%)
Alachua	Alachua	2		2		
	Gainesville	1			1	
	LaCrosse	0				
Broward	Dania	2			2	
	Deerfield Beach	3			3	
	Ft. Lauderdale	1	1			
	Pompano Beach	6	2	3	1	
Collier	Immokalee	13	5	1	7	
	Ochopee	1				1
Dade	Florida City	1	1			
	Homestead	5	3	1	1	
	Miami	1			1	
	Perrine	18	12	3	3	
	Princeton	2	2			
Hendry	Clewiston	1			1	
	LaBelle	14	7	5	2	
Hillsborough	Tampa	10		1	9	
	Ruskin	1			1	
Lee	Alva	4		4		
Manatee	Bradenton	7	1	3	3	
	Palmetto	6			6	
Marion	Ocala	3	3			

Table 2 cont'd

County	Key Town	Total Referrals Received	Disposition: Complete Service	Partial Service	No Service	No Evaluation
Palm Beach	Belle Glade	31	15	9	7	
	Delray Beach	7		2	5	
	Pahokee	2	2			
	W. Palm Beach	1			1	
Pasco		1			1	
Polk	Auburndale	1			1	
Putnam	Palatka	2		1	1	
Sarasota	Sarasota	15	7	4	4	
St. Lucie	Ft. Pierce	1			1	
Seminole	Sanford	2	1	1		

Table 3

Disposition of Migrant Health Service Referrals
Made from Florida to Other States

Referred From:	Referred To:	Disposition: Complete Service	Partial Service	No Service
Collier	Texas (2)	1	1	
Dade	Virginia (1)			1
Palm Beach	Texas (1)	1		
	N.Y. (1)	1		
Lee	N.J. (1)	1		

The referrals carried 292 requests for service, resulting in the following:

Table 5

CATEGORY	NUMBER OF SERVICE REQUESTS	PERCENT
Total	292	100.0
Partial	76	26.0
Complete	99	34.0
None	116	39.7
Not Reported	1	.3

Thus, 175 (60.0%) of the requests resulted in service - either partial or complete - being rendered to patients.

Types of Service Requests: Requests for Immunizations, health appraisals, and prenatal care accounted for 192 (62.3%) of the total requests. A more complete distribution is shown here:

Table 6

Disposition of 179 Migrant Health Service Referrals by Nature of Service Requests

Service Requests	Total	Disposition: Complete Service	Partial Service	No Service	Not Reported
TOTAL	292	99 (34.0)	76 (26.0)	116 (39.7)	1 (.3)
Cancer cytology	3	2	1		
Chest X-ray	26	6	3	17	
Child spacing	20	6	7	7	
Health appraisal	71	23	17	31	
Immunizations	80	29	23	28	
Nutrition	13	6	5	2	
Postpartum	10	2	2	6	
Prenatal	41	14	13	13	1
Diabetes	4	2	1	1	
Int. Parasite	4	1	1	2	
Rheumatic fever	2	2			
Tuberculosis	8	1	2	5	
Venereal disease	2	1	1		
V.N.A.	0				
Crippled child	5	2		3	
Vocational rehab.	0				
Other	3	2		1	

Characteristics of Patients: Several cultural groups were represented among the patients referred: Negro, Spanish, Anglo, and Indian. Ages ranged from under one year to more than 60 years. Tables 7 and 8 show the characteristics.

Table 7

Distribution of 179 Migrant Patients by Sex and Cultural Group

CULTURAL GROUP AND SEX	NUMBER	PERCENT
Total	179	100.0
Negro Males	43	24.0
Negro Females	77	43.0
Spanish Males	17	9.4
Spanish Females	30	16.8
Anglo Males	1	.6
Anglo Females	4	2.3
Other	1	.6
Not Reported	6	3.3

Table 8

Distribution of 179 Migrant Patients by Age Group

AGE GROUP	NUMBER	PERCENT
Total	179	100.0
Under 1 year	32	17.8
1 - 5	23	12.8
6 - 10	16	8.9
11 - 15	11	6.1
16 - 20	28	15.7
21 - 25	21	11.7
26 - 30	13	7.3
31 - 35	10	5.6
36 - 40	5	2.8
41 - 45	8	4.6
46 - 50	2	1.1
51 - 55	2	1.1
56 - 60	1	.6
61 - 65	1	.6
Not Reported	6	3.4

The majority of patients referred were quite young. One hundred thirty-seven (70.9%) of the patients were not more than 25 years of age.

A majority of the patients were sought out by public health personnel. In only five cases was service not provided when a public health worker sought and located the patient.

Table 9

CATEGORY	NUMBER OF REFERRALS	PERCENT
Total	179	100.0
Patient sought service	21	11.7
Pt. sought out by Public Health Personnel	81	45.2
Unable to locate patient	61	34.1
Not Reported	16	9.0

Among the 61 patients not receiving service, a sizeable number of referrals had no specific directions as to patient location information, thus no attempt was made to locate the patient.

Of the 21 patients who presented themselves for service (or in the cases of children, were presented for service), the age range was under 1 year of age to 41. Sixteen (76.1%) were females; all cultural groups were represented. In only one case was service not rendered partially or completely. This, because the patient (a 19 year old Anglo female) went for prenatal services on a "non-clinic day".

The services for which this group was referred include: prenatal care, immunizations, health appraisals, child-spacing, postpartum care, and follow-up care for rheumatic fever and epilepsy.

Those who presented themselves for service were referred from the following places:

Table 10

STATE	COUNTY	NUMBER	PERCENT
Total	-----	21	99.5
Florida	Collier	2	9.5
	Dade	8	38.1
	Palm Beach	2	9.5

Table 10 cont'd

STATE	COUNTY	NUMBER	PERCENT
North Carolina	Henderson	2	9.5
Ohio	Lucas	3	14.2
Virginia	Accomack	2	9.5
	Northampton	2	9.5

Summary and Conclusions: Of 179 migrant patients referred for health services under the Health Service Index system, 112 (62.6%) received services, either partial or complete, with regard to the service requests. Total requests for services numbered 292, 175 (64.0%) being provided partially or completely. Immunizations, health appraisals, and prenatal care accounted for 192 (65.7) of the service requests, being met partially or completely in 119 (61.9%) instances.

The patient group was comprised of these cultural groups: Negro, Spanish, Anglo, and Indian, the largest being Negro; 112 (63.1%) of the group were females. Seventy per cent of the group was under 25 years of age.

Twenty-one (11.7%) of the patient group sought the services for which they were referred. Twelve were under 17 years of age.

Insufficient patient location information provided by initiating agencies was reported as a major reason for inability of public health personnel to locate patients, resulting in no service being provided.

In some cases, referrals were held by receiving agencies for an insufficient period of time to allow the migrant to arrive in the area to which he had been referred.

In general, the referral forms were fairly complete. In only one instance was the Referral Evaluation section omitted completely. However, a sizeable number appeared with only one evaluation item marked.

While this review is by no means an exhaustive analysis, it does suggest that the referral system has produced results sufficiently positive to warrant further, more intensive activity directed toward broadening its usage. The most obvious

Copy Sent 6/18/65

MIGRANT HEALTH SERVICE REFERRAL

Referred from: 3 3 9 3 4
Col. 1 2 3 4 5

Patient name: Valdez Rosa
last first middle

Col. 6 Male ☐ Female ☒

Col. 7 Under 1 yr. old ☐

Col. 8 9 Age in years 2 1

Col. 10 Negro ☐ 1 Spanish ☒ 2 Anglo ☐ 3 Other ☐ 4

Service Request:

Col.		PREVENTIVE
11		cancer cytology
12		chest x-ray
13		child spacing
14		health appraisal
15	X	immunizations
16		nutrition
17		postpartum
18	X	prenatal

		CURATIVE
19		diabetes
20		intest. parasite
21		rheumatic fever
22		tuberculosis
23		venereal disease
24		V.N.A.

		REHABILITATIVE
25		crippled child.
26		vocational

Health Service Instructions: Prenatal E.D.C. 8 ?. 65
Had Neg VDRL, Neg Gc smear, Neg Pap smear
1-11-65 Positive RH, H.B. 14.3 gms. Instr
Pt to come to Health Dept to continue
service

Patient Location Information: Hollywood & Ben
Guerero crew leader Sutton's Plantation

Col. 27 28 29 30 31
Referred to: 2 9 4 4 9

Col. 32 33 34
Date: 5 27 65
Mo. Yr.

Authorized signature: J Blake Palmer P.H.N.

PLEASE NOTE: Upon provision of service requested or after 60 days following receipt of referral, please complete REFERRAL EVALUATION (below), fold so that the referral will be sent to FLORIDA STATE BOARD OF HEALTH. The reverse side of this sheet is already addressed. Postage is guaranteed.

REFERRAL EVALUATION

Please mark all items which apply:

Col.

35		Request for service was provided
	X	1. Partially
		2. Completely
36		Requested service was not provided
37		Patient sought service requested
38	X	Patient was sought out by PHP*
39		Unable to locate patient

*Public Health Personnel

Comments: Seen at night clinic
on 6/14/65 - Wt 97 lbs BP 100/70
Urine-OK no edema.
Pt had all Lev papers with Lev
& information was helpful -
Referred to H D in Traverse city Mich

Col. 40 41 42
Date: 6 15 65
Mo. Yr.

Authorized signature: Roberta J Bessette

A completed Migrant Health Service Referral Form which originated in Florida, was sent to South Carolina in time to assure further service there. Another Referral was sent on this patient from South Carolina to Michigan which assured continuity of health service.

shortcomings noted during the review are those which may be overcome by means of effective communication with public health personnel utilizing the system.

RESIDENT INTEREST IN MIGRANTS

Three steps involving public relations are necessary for any new program to achieve success. First, the public must become aware of the program and the reasons for its existence. Second, the public must become interested in the program. Third, the public must cooperate with the program.

To say simply that there was an increase of interest in agricultural migrants this year would be a definite understatement. More interest was evinced by the general public in Florida's migrants and their problems this year than at any time since the disasterous freeze and floods of the 1957-58 season. Credit for generating this interest cannot be bestowed on any one event, person, agency, program, or medium of publicity. Rather it was, in a way, a fortuitous combination of circumstances that caused a chain reaction favorable to the migrants. It might be appropriate here to list (not necessarily in the order of their importance) some of the contributing factors.

1. The launching of the Migrant Project: This event received quite wide publicity in all of the Florida newspapers, especially those published in Project counties or contiguous counties. People read accounts of the funds being granted, what they were to be used for, and why.
2. Distribution of the Florida film - "The Season People": This documentary film was given or loaned to several counties and was shown to the public by health department personnel whenever the opportunity presented itself.
3. Televising of the new WTVJ film - "Hands for Hire": The special program on which the film was shown was viewed by people in south Florida within a radius of approximately one hundred miles from Miami and engendered widespread interest in migrants.
4. Curtailment of offshore labor: The action of the U. S. Department of Labor in barring future use of offshore labor in Florida fields and groves received widespread publicity through all news media in the State. A serendipitous effect of this was the focusing of the public's attention upon the domestic migrants.

5. Shortage of migrant labor: Shortages that developed in meeting growers' needs for field and grove hands received wide publicity. As a consequence, many people finally came to realize that there was a definite connection between the food on their tables and the migrant workers who helped to put it there.
6. Inauguration of the Poverty Program: The various ramifications of the Poverty Program, especially Community Action Programs and VISTA training were played up to the hilt by Florida newspapers and television. Because many of the Community Action Programs involved areas of high migrant concentrations, people who heretofore had been unaware of the migrants' problems, became better informed.
7. Feature stories on migrants: Several Florida newspapers ran feature stories, editorials, and series of articles on the migrants' problems and way of life. In many counties, one would have had to be illiterate to avoid the veritable deluge of words which spewed forth from the newspaper presses describing all facets of the migrants' existence. Some reporters went so far as to obtain jobs (incognito) working with the migrants to lend credence to their articles. Several reporters contented themselves merely with visitng fields, homes and "juke joints" interviewing migrants, growers, and landlords and reporting what they learned to their readers in articles with photographs depicting the conditions that they found.

It is not possible to determine how deeply all of the information on migrants sunk into the public's mind. Certainly, a deep impression was made on many people, and it can only be hoped that the flame of interest stirred up can be kept alive and not die down as it did seven years ago.

Health department personnel connected with the Migrant Project have endeavored to "cash in" on the new peak of interest by soliciting aid from the general public and particularly from church, fraternal, civic, and professional organizations to assist in making the Project a success. A typical example of

cooperation with a health department from organizations now interested in migrants may be found in the Collier County section of this report under "Other Items Pertinent to Future Project Development".

The film, "The Season People", has been viewed this year by hundreds of people, including many city, county, and State officials. The Project has acquired a kinescope of the T.V. film "Hands for Hire" which will be shown in conjunction with "The Season People". A portable exhibit portraying health department services available to migrants has been set up at many conventions and meetings to illustrate the Project's scope.

Several hundred copies of the Florida monographs "On the Season" and "They Follow the Sun" have been distributed. Many letters have been written by Project personnel explaining details of the Project and its aims to interested persons who have requested information on the migrant program in Florida. Speeches and talks by State and County personnel explaining the Project have been made to audiences numbering in the hundreds.

When the Florida Citizens Committee on Agricultural Labor was reactivated in March, the Project Coordinator became a member. The Coordinator is also a consultant on migrant labor to the Community Service Foundation which has been funded under the Economic Opportunity Act. The Foundation has proposed --- to inaugurate and operate a program for the betterment of conditions of scores of thousands of migrants and other seasonal agricultural workers and their families in the State of Florida. Of the fourteen counties included in the program, seven are Project Counties.

There has been a ground swell of interest displayed by many organizations and clubs in the need for day care centers to care for the children of migrant parents while the adults are at work. Similarly, the intra-state transportation of migrants has aroused much interest on the part of both the general public and some legislators. Representative Emmett Roberts, a long-time staunch supporter of legislation designed to improve the migrants' lot, introduced a bill in the Florida Legislature this spring to regulate transportation of migrants.

Even in those instances when residents complained because migrants were moving into their neighborhoods, the resultant publicity focused the attention of the public on the migrants' need for more and better housing, day care centers, medical services, health education, etc.

To conclude this section of the report, it is an indisputable fact that a large segment of our resident population has become aware of the migrant labor force in the State and that the migrants have more than their share of problems. A considerable number of our residents have become both interested in the migrants and in the aims of the Project. It only remains now to convert their interest into constructive action for the enhancement of the Project's success.

Foreign Harvest Hands Barred, Growers Told

BELLE GLADE, May 21 (AP) An assistant secretary of agriculture flew to Florida today and

New public health program starts for migrant labor camps

Fund Drive Is Launched For Mobile Health Unit

Florida Crops In Labor Pinch

State Committee Discusses Plight Of Migrant Workers

Manatee Club Seeks Better Housing for Farm Migrants

Migrant Clinics To Be Opened

Church Workers Assist Migrants

Medically Equipped Trailer Visits Farms

Health Unit Elects; Discusses Migrants

State Extends Migrant Worker Health Program

Health Council Installs, Hears Migrant Report

County Migrant Laborers To Be Included In State Basic Care Health Program

County Okays Labor Camp

In spite of strenuous protests of and threatened legal action by property owners near a migrant labor camp being constructed by

Commissioners View Movie On Farm Labor

Immokalee Migrant Committee Will Open Child Care Center

A sample of some of the numerous articles written about migrants during the Project year.

PROJECT OBJECTIVES

1. To continue to provide opportunity for State and local public health officials and others to evaluate the program for migrants and to plan for its improvement.

2. To implement the basic service program on a statewide basis.

3. To prepare and print 15 pamphlets in English and 10 in Spanish suitable for use with migrants.

4. To offer comprehensive medical treatment, except hospitalization, in Broward, Highlands, Glades , Hendry, Lee, and Collier Counties.

   a. Through limited treatment in health department clinics.
   b. Through referral to private physicians on a contract basis.

5. To offer specified types of dental services to migrants in Lee and Collier Counties by referral to private dentists on a contract basis.

6. To help solve the migrants' problem of transportation.

   a. Through the use of a mobile clinic in Broward County.
   b. By transporting the migrants to doctors' offices both in and outside of Collier County.

7. To revise and make full use of the referral system, if it is found to be practical.

Objective 1: To continue to provide opportunity for State and local public health officials and others to evaluate the program for migrants and to plan for its improvement.

This objective has been substantially met on an indivudual basis through visits of the Coordinator to Project counties. The health department directors and their personnel who have been contacted have delivered themselves of opinions gauging the effectiveness of the migrant program and have discussed their several problems and various plans for the improvement of the program. All of the directors felt that the program has been effective and should be continued. Most of them felt that it should be broadened. Many

found that the services offered would be taken advantage of by greater numbers of migrants if there was an increase in Project personnel to render more service. Some felt that the paperwork involved took time that could better be spent in field or clinic work.

Many of the plans suggested for improving the program evolved around a step-up in activities either by increasing the number of services, or lengthening the duration of time that the services were offered. In several counties this would, they felt, necessitate the employment of additional personnel and an increase in funds for the categories of Supplies, Travel, and Other. Several directors felt that their field personnel were ham-strung by limited travel funds this year, and thus their program's effectiveness was hampered.

The directors of Sarasota, Flagler, and Putnam County Health Departments received their funds too late in the season to get their planned programs underway and consequently could not evaluate their activities. The Manatee County Health Department director experienced some difficulty in obtaining qualified personnel until practically the end of the season, and was in the same position as the directors listed in the preceding sentence, as far as evaluation is concerned.

An unlooked for problem which hampered the program in some counties was the turnover in Project personnel. Qualified public health nurses and sanitarians are not plentiful in Florida, and it took valuable time to train replacements for personnel who left the Project in the middle of the season.

The factor of newness was another problem which had to be overcome. Some health departments found that there was a considerable difference between putting their plans on paper and carrying the plans out. Some procedures had to be revised,

methodology had to be retooled to fit situations different from what had been envisioned. Frustration occurred when the difficulty of separating migrants from indigent residents was experienced in some areas. It also occurred when migrants did not act as they were expected to act and broke appointments, failed to follow nurses' and physicians' directions, left areas without leaving forwarding addresses or information as to their destination, etc. New personnel experienced for the first time, the difficulties of trying to make themselves understood by people who spoke little or no English. Several Project personnel are now studying Spanish to overcome this language barrier.

Funds were granted too late in the season for the planned meetings of Project personnel to be held. It would not be advisable to hold meetings during the summer, as many of the Project personnel will be on vacation. The first meeting is scheduled for September, at which time, plans for the remainder of 1965 will be discussed, among a variety of other items. Additional meetings will be held later in the year.

Additional information relative to this first Project Objective may be found in the county reports section of this Annual Report.

Objective 2: To implement the basic service program on a statewide basis.

This year, eight additional counties joined the previous 14 counties that offered a basic service program. The new counties are: Flagler, Hardee, Hillsborough, Orange, Polk, Putnam, Seminole, and Volusia. All of these counties host migrants during the season. By the end of 1966, we hope to include many of the other 20 counties in the State in which migrants live and work. Doubtless, more counties would have been included this year, if there had been sufficient time for staff personnel to contact them and discuss the basic service program.

Objective 3: To prepare and print 15 pamphlets in English and 10 in Spanish suitable for use with migrants.

In order to meet this objective, it was found necessary to reduce the number of pamphlets from 15 to 10. The preparation of pamphlets was found to be a more complicated and time-consuming task than had been anticipated.

A part-time health educator was employed on November 1, 1964. After spending a period of time familiarizing herself with migrant problems in several counties having migrants, work was started on the pamphlets.

A schedule was set up with calendar deadlines to meet in order to complete the project by August 31, 1965. This schedule included the following for ten pamphlets: a rough copy ready for the artist; artist rough copy for a black and white printing for testing; completion of the black and white printing; black and white printing tested; test results returned and evaluated; corrected copy to the artist; camera-ready copy for bid; bids released; final printing (in color) completed. Testing (from four to twenty-five copies each) were sent to 22 counties. Some replies were very thorough and detailed, while others were very general. An example from Seminole County for the pamphlet on Diarrhea: Comments (after specific questions answered): "Perhaps an illustration of fruits and vegetables more commonly understood might help. Guts is not a familiar term to any of our patients. They felt they would use stomach or upset the bowels. We like the pamphlets very much and do hope they will soon be available to us".

The schedule was a tentative one and problems have been encountered. For example, much more time was needed for the artist to do certain phases of his work. Also, the testing results and evaluations were very slow in coming in as scheduled. Finally,

when the bid had been accepted by a printer, there was a two-week delay in getting the paper stock, so allowances had to be adjusted for this delay.

As of this date, ten pamphlets have been written in the black and white printing; two are at the printers for final printing (10,000 each in color), which should be completed by July 15, 1965; bids have been sent out for two; four are at the artists being completed for camera-ready copy; and two are in the field being tested. The topics of the pamphlets are as follows: Roundworms, Hookworms, Diarrhea, Garbage, Pre-Natal Care, Baby Immunization, Adult Immunization, Planned Parenthood, Venereal Disease, and Sores.

It is expected that the ten pamphlets in English will be completed by September. None have been translated into Spanish yet, but this will be done as planned.

Objective 4: To offer comprehensive medical treatment, except hospitalization, in Broward, Highlands, Glades, Hendry, Lee, and Collier Counties.

a. Through limited treatment in health department clinics.
b. Through referral to private physicians on a contract basis.

This objective has been met fully in Broward, Glades, Hendry, and Collier Counties. It has not yet been met in Highlands County. It has been partially met in Lee County.

Broward: In Broward County, two private physicians rendered comprehensive medical treatment to migrant workers and their dependents. Limited treatment was carried on in regular health department clinics.

Glades and Hendry: Both Glades and Hendry Counties carried on limited treatment in the health department clinics and in a Camp clinic. Negotiations between the health department director and a California private physician who was interested in serving as a Clinician in migrant clinics for the two counties dragged on for

months, but the physician never did appear. This restricted the program's effectiveness, as fewer clinics were held than originally planned, and consequently, fewer migrant patients were treated in the clinics. This situation will be cleared up in the near future, as arrangements have been finalized for the employment of a clinician, effective in July.

Referrals were made to private physicians in these counties to enable migrants to receive comprehensive medical treatment. Physicians were reimbursed from Project funds. Four dollars was paid for the first visit and three dollars for each additional visit for the same ailment.

Collier: Migrant workers and their dependents received limited treatment in the Collier Health Department clinics. Referrals of migrants were made to private physicians, both in and out of the county for comprehensive medical treatment. The same fee schedule was used as in Glades and Hendry Counties.

Highlands: In Highlands County, the health department offered limited treatment to migrants in its regular clinics. Difficulty of migrant identification, plus lack of adequate personnel, hindered somewhat the program's effectiveness. No referrals to private physicians in the county were made, as they did not indicate any willingness to accept referrals on a contract basis. This county is a component of a tri-county unit which includes Glades and Hendry counties, so the same situation existed here in relation to restriction of services due to lack of a clinician. As in Glades and Hendry, the problem should be solved in July.

Lee: The director in Lee County was unable to make any arrangements with private physicians in the county to either staff the planned migrant clinics or accept referrals from the health department. The director proposes to solve this problem by hiring a clinician part time who would be a county employee.

Medical treatment was rendered Spanish-speaking migrants at a clinic by a private physician who volunteered his services one-half day each week. This physician referred many patients to private physicians in the county for further and more comprehensive treatment. These referrals were honored gratis. The health department clinics rendered limited treatment to migrant patients as usual.

Emergency room treatment was given to migrants from Glades, Hendry, and Collier Counties on a reduced fee basis worked out between the health department directors and the hospital administrators.

Additional information relative to this Project Objective may be found in the county reports section of this Annual Report.

Objective 5: To offer specified types of dental services to migrants in Lee and Collier Counties, by referral to private dentists on a contract basis.

This objective has been met in both Lee and Collier Counties. Dentists were reimbursed from Project funds and were paid on a schedule similar to the rates used by the Veterans Administration. In addition, migrant children have received dental attention in Collier County from the health department dentist. In Lee County, a trailer is being converted into a dental mobile clinic which will be manned by a dentist when the State Board of Health assigns one to the county. See the county reports section of this Annual Report for additional information relative to this Project Objective.

Objective 6: To help solve the migrants' problem of transportation.

a. Through the use of a mobile clinic in Broward County.
b. By transporting migrants to doctors' offices, both in and outside of Collier County.

This objective has been met in both Broward and Collier Counties.

The mobile clinic in Broward County has been utilized this year

to bring services to the migrants. It is planned to increase the use of the mobile clinic when the migrants return in the fall. In addition to the mobile clinic, a field clinic was set up this year in the county's largest migrant camp. Day and night clinics for migrants were held here. This also helped to alleviate, to some extent, the migrant's problems of transportation to clinics for services.

In Collier County, the small bus assigned to the county for transportation of migrants for medical services was put to good use. Delay in delivery of the bus until January reduced the number of migrants who could have received service.

In addition, the problem of transportation of migrants from a large camp in Hendry County to the health department clinic and to private physicians' offices was solved by the use of volunteer drivers. When these volunteers were not available, a migrant was reimbursed for bringing the patients in on a truck.

See the county reports section of the Annual Report for additional information on this Objective.

Objective 7: To revise and make full use of the referral system, if it is found to be practical.

The migrant health service referral system is still considered to be in the experimental stage. A review of over 175 referrals is discussed in a preceding section of the Annual Report. The form has not been revised as yet, although some recommendations for certain revisions have been received from Project personnel and others. Some of the recommendations which have been taken under advisement are:

1. The need to develop an additional form to be used for an entire family or appropriate revision of the existing form to enable it to be used for either family or individual referrals.

2. Allow more space on the form for health service instructions.
3. Use multi-copy forms to determine, among other things, the number of referrals actually initiated, compared with the number resulting in service to migrants.
4. Issue a stamped post card to the migrant which contains the referring health department's address. If the migrant mailed back the card when he reached his destination, the referral form would be sent to the health department in that area. Thus, patients would not be "lost" either because they did not know where they were going, or went to a destination different from the one given to the referring health department.

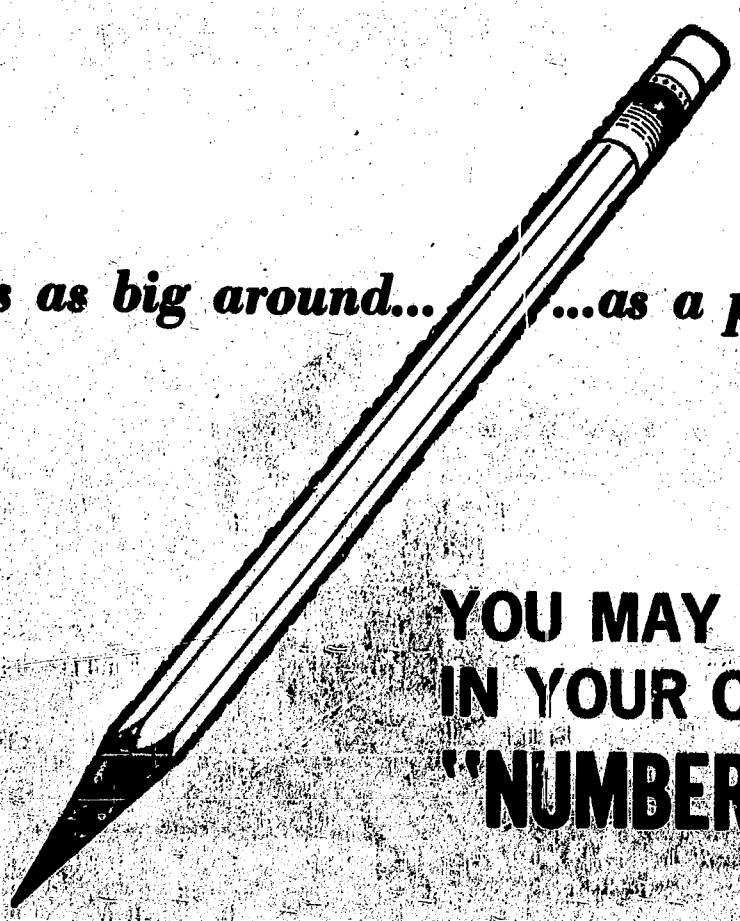
A short-term evaluation of the referral system will be attempted on referrals made during a period extending from July 1 to October 31, 1965. Forms have been sent to the State Health Departments of Virginia, South Carolina, and New York, on which referral information will be noted for evaluation of results from the three states after the four-month period expires.

Health Service Indexes, the basic tool of the system, have been developed for Florida, Virginia, South Carolina, New York, and Delaware. The system has found acceptance beyond the five-state area and is in varying stages of development in Maryland, New Jersey, and Ohio. Interest in participation is evident also in North Carolina, Georgia, Pennsylvania, and Puerto Rico. It is presently being used in 22 Florida counties.

Florida health officials feel that the referral system will be in widespread use in the future. This will aid immeasurably in assuring continuity of health services for agricultural migrants in our country.

This is a... ROUNDWORM or a STOMACH WORM

It is as big around... ...as a pencil!



YOU MAY SEE THIS WORM IN YOUR CHILD'S... "NUMBER TWO" (STOOL)

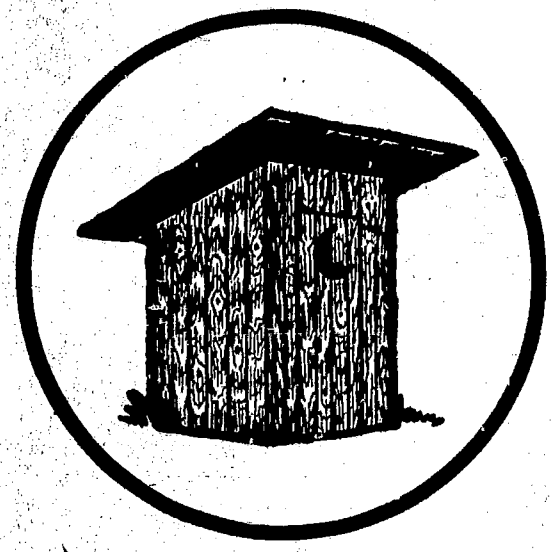
Your CHILD may have these WORMS without knowing it.

- He may NOT be EATING WELL.
- He may NOT be SLEEPING WELL.
- He may feel TIRED.
- He may have a STOMACH ACHE.
- He may CRY A LOT.

WHAT TO DO?

ALWAYS...

...use the TOILET



...or OUTDOOR PRIVY

TEACH your CHILDREN to WASH their HANDS after using the TOILET.

IF ONE PERSON IN YOUR FAMILY HAS...

STOMACH WORMS

...OTHERS MAY HAVE THEM TOO.

ASK THE **NURSE** FOR SOME BOTTLES SO THE **"NUMBER TWO"** (STOOL) CAN BE TESTED.

FLORIDA STATE BOARD OF HEALTH
IN COOPERATION WITH U. S. PUBLIC HEALTH SERVICE

ALACHUA COUNTY HEALTH DEPARTMENT

Edward G. Byrne, M.D., Director

Area of county: 892 sq. mi.

Resident Population: 86,500

Number of Migrants: 3,500

Migrant Project Staff: 1 Public Health Nurse

Period covered in this Report: September 1, 1964 - May 31, 1965

ALACHUA COUNTY

Migrant Situation

The primary peak of migrant workers in Alachua County occurs from April until July. During this period, the number of laborers fluctuates between 1,000 to 1,500, plus dependents. During this peak, the average total migrant population is judged to be in excess of 3,500. A secondary peak occurs in late summer, but the number of migrants at this particular time would total probably only one-quarter of those present during the primary peak. There are some in-state migrants throughout most of the year, but they rarely exceed 100 in number. Crops in Alachua County include potatoes, squash, celery, beans, and cucumbers.

In previous years, the migrant labor force has been composed primarily of Negroes with a scattering of Anglos and a small number of people of Spanish descent. It was noted this year, however, that there was an appreciable increase in the influx of Texas-Mexicans. The ethnic makeup of the migrants this year is estimated at 90% Negroes and 10% Texas-Mexicans.

Most of the migrants originate in Dade, St. Lucie, Sarasota, Broward, and Palm Beach Counties. They come to the farming areas of Alachua County from Homestead, Ft. Pierce, Sarasota, Pompano, and Delray Beach. While in Alachua County, they tend to congregate in an area roughly bounded by Newberry, Alachua, La Crosse, Santa Fe, and High Springs. Many of the workers migrate from Alachua County to Samson County, North Carolina. Others move up to eastern Virginia and to Delaware with some going to Michigan. From these stops, they move on into New York, New Jersey and Pennsylvania for work before they start their trek south again. Only in an occasional case does Alachua County become the permanent home of any migrant laborers.

As yet, mechanization has had no appreciable impact upon the use of migrant labor in the county. There are indications, however, that this may come to pass within the next three or four years.

Sanitation

During the year there were no legally permitted camps operating within the previously mentioned migrant area of the county. Due primarily to lack of sanitation personnel, the health department has been unable to give close observation and supervision for the last three years to migrant housing. It now appears that existing housing in the area of migrant concentration should be brought up to standards and licensed or where appropriate - closed down. The health department is cognizant of the fact that housing, medical, and sanitation services go hand in hand, especially in a rural county. The value of services rendered by the first two disciplines is diminished if poor sanitation prevails in a migrant area.

Towards the end of this year, the sanitation staff contacted the District Farm Labor Representative who represents Alachua and five surrounding counties for the Florida State Employment Service. The contact worked out particularly well, because the Employment representative had formerly worked for a short while as a sanitarian for the department and there were good personal relationships. As a result of discussions with this Employment representative, tentative plans have been made for an extensive cooperative program to be carried on during the remainder of 1965 in preparation for next year's migrant season.

Nursing and Medical

Two types of clinics, nursing and general medical, were held this year in the town of Alachua which is centrally located in the migrant area. Nursing Clinics operated from 10:00 a.m. to 4:00 p.m. on Mondays and were staffed by two staff nurses, one paid worker, and two volunteers. Medical clinics operated from 9:00 a.m. to noon every other Tuesday with the same staff, plus a physician.

Total attendance at the medical clinics was 498, the nursing clinic counted an attendance of 2,154. During the year, some of the people also received service by other health department staff, such as the physical therapist, mehtal health worker, nutritionist, and other consultants.

Approximately two-thirds of the patients seen in the clinics were in an adult age range and the remainder were children. The number of aged was very small. The vast bulk of the adults were female. The exact number of these patients, who were migrants, was not recorded; however, during peak seasons, about 25% of the total population of the area are migrants, and it is felt that they received their proportion of services. It is planned to install a record keeping system which will provide this necessary data for future reports.

Only a modest number of referrals were made to other agencies, such as a dental clinic, University of Florida Hospital, Private physicians, etc. It was found that very few individual migrants would take the reponsibility for carrying out their referrals, though some assistance was obtained from crew leaders and occasionally from growers. Health education directed to migrants was extended, in some cases, through the growers and crew leaders. From staff members, many migrants received individual counseling in matters of venereal diseases, tuberculosis, maternity care, child spacing, nutrition, personal hygiene, and immunization needs of children and adults.

Although 30 patients were given health records with instructions to see a doctor someplace else in the migrant stream, not one migrant presented a health record during a clinic session in the entire county. During the year, contacts were made with growers, crew leaders, local physicians, tuberculosis associations, V.D. investigators, and crew leaders' wives. The purpose of this contact was to solicit improved health care for the migrants. It is felt that improved service will require facilities that are located immediately adjacent to the work area or camp. Services of this type should be made available during the workers' mid-day break period and/or during the early evening hours. Several problems arose this year, among them being the difficulty of working with migrants because of the scattered locations and a lack of interest and cooperation on the part of most growers. The nursing staff found that the best way to work with the migrant was to give a special customized service to these people.

It was felt this year that the department enjoyed very limited success with the migrants, but the nurse in the Project area believes that this can be attributed to her lack of previous experience in working with migrants. The nurse was employed on October 1. She feels that a second year of exposure to these people will result in a better and more productive contact. It is felt that during the coming year, the health department's mobile clinic should be used more extensively with the migrants and that there is need for extra sanitation work in the migrant housing area.

This year there were two full-time staff nurses working in the general migrant labor area as well as two part-time nurses. There were three part-time paid employees and three volunteer employees for the clinic operations. The Project nurse estimates that there are eight to ten "pockets" of population concentrations that have received service. The major deficiencies noted in these areas were garbage disposal and inadequate sewage treatment facilities. The nurse was particularly impressed that food storage seems to be fairly well handled.

Of the approximately 1200 field visits made in the northwest section of the county where migrants are most numerous, 20 per cent were to migrant families. An estimated 60 per cent of those visited in the home received some type of referral for additional services, most of which were offered in the health department clinics. About 10 per cent received referrals to other agencies, such as the Pediatric Charity Clinic, Welfare Department, etc. About one-half of those given referrals carried through and completed the referrals. The chief reasons for non-completion were apathy and lack of transportation.

The total lack of camp organization and centralized health facilities in the camps seems to be a major hindrance to proper service. The most useful approach to the migrant appears to be through the wives of the crew leaders and by personal contact by the nurse.

FUTURE PLANS

After the initial year of experience with the Migrant Project, personnel

of the Alachua County Health Department feel that they have only begun to understand the problems involved and to develop the elementary competence to handle them. When the health department entered the Project, they believed that slightly increased personnel in the nursing section would compensate for the increased work necessary for other members of the staff. This belief has proven to be false.

Experience during the first year suggests the following:

1. Reinforcement of sanitation services in the migrant area with primary emphasis on developing the pockets of migrant housing concentration into organized camps meeting minimum Florida State Board of Health standards.
2. Development of some means of financial reimbursement for medical care for migrants, whether it be for visits to private physicians' offices, use of emergency rooms, purchase of drugs prescribed or for the hiring of physicians to hold special clinics.
3. More extensive use of the mobile clinic in the migrant area, especially during hours that the migrants may avail themselves of the opportunity to visit the clinic.
4. The inauguration of a system of forms and record keeping which will provide data on migrants necessary for both self-evaluation of the health department's program efforts and for future reports.

ALACHUA COUNTY

X INDICATES CLINIC

4 MILES

N

MIGRANT

LEFT: A bus converted into a mobile clinic serves migrants in Alachua's outlying districts. Transportation to clinics is a problem for many migrants.

BOTTOM PICTURES: Condition of housing varies in migrant area of Alachua County as it does in most counties.

BROWARD COUNTY HEALTH DEPARTMENT

Paul W. Hughes, M.D., Director
E. Henry King, M.D., Project Director

Area of County: 1218 sq. mi.

Resident Population: 400,000

Number of Migrants: 5,000

Migrant Project Staff: 2 Public Health Nurses
1 Sanitarian
1 Clerk-Typist

Period covered in this Report: September 1, 1964 - May 15, 1965

BROWARD COUNTY

After about two years of planning and discussion, implementing funds for the Migrant Program in Broward County were provided on November 1, 1964. With these available, the supervising nurse for the program was hired. The months of November and December 1964 were spent by the supervising nurse and the Project director in procurement of facilities, equipment and supplies, and the recruitment of personnel.

Much earlier in the planning phase, it had been decided that a medical clinic for the migrants, in which they would receive emergency medical care and medications, was of paramount importance. It was further agreed that this clinic needed to be located where the migrants lived and worked, and should be open in the evening, when their work in the fields had finished. With this view in mind, a detailed topographic survey was made of northern Broward County where most of the field operations were concentrated. The initial premise was that, in order to reach the migrants, it would be necessary to utilize the health department's mobile clinic. The survey demonstrated that most of the farmers no longer maintained quarters for the migrants. Also, many of the farmers had moved the headquarters of their operations to Palm Beach County lying to the north, although still maintaining fields in Broward County. As a result, most of the migrants had moved into existing community residential centers located in and around the Pompano Beach Farm Labor Camp on Hammondville Road. About this time, Colonel George Dewey, Manager of this Camp, offered free use of a vacant five-room cottage located on the grounds of the Labor Camp and this was accepted for use as a clinic for the migrants. Colonel Dewey undertook voluntarily, and at his own expense to clean, paint, and make this space ready for occupancy. Meanwhile, with no funds allowed in the Migrant Project for equipment, discarded items were resurrected, washed, and spray painted by the nurses assigned to the program. These items included medical equipment, office and general furniture. Certain items, such as a microscope and shelving to store drugs, had to be purchased out of health department funds.

With the help of a local pharmacist, who donated his services, a list of drug items was prepared and checked both by the Project director and Robert Burry, M.D., a practicing physician in Pompano Beach, who had agreed to serve as a clinician with the Project. Several weeks during November and December were spent placing bids and orders for drugs, drug containers, and other supplies, the county purchasing agent donating his services for this purpose.

As January 1, 1965 approached, another clinician, Vincent J. Strack, M.D., made arrangements to alternate clinic service with Doctor Burry and a second public health nurse was employed. During this month, the clinic was started at the fixed location provided by Colonel Dewey and from its inception, provided two afternoon and two evening clinics of approximately two hours each. Initial growth of this clinic was slow, but within a week or two, a steady flow of migrants in need of medical care was finding its location. After about two months of operation, it was decided to give a trial run of the mobile clinic in the Deerfield area, approximately 10 miles north, where a few growers still maintained family living quarters. The clinic was run on a one-night a week basis for approximately three hours and was very well attended. This experience demonstrated that at least in this county, a judicious combination of both fixed and mobile operation worked best.

At the time of the preparation of this Report (mid-May 1965), the number of migrants still in the area and attending the clinic are both diminishing and while the clinic will continue its operation during the summer months, more effort will be concentrated in field development among growers and migrants so that by the next crop season in the Fall, the Migrant Medical Program may be considerably expanded.

The operation of the clinic program so far has been handicapped by the unavailability of a person to perform as a clerk and clinic aide. This has meant that both nurses assigned to the program have had to work the clinics together instead of one working in the field. It should be mentioned here that both nurses have carried on field activities when not serving in the clinics. In addition, no janitorial service was provided and professional time

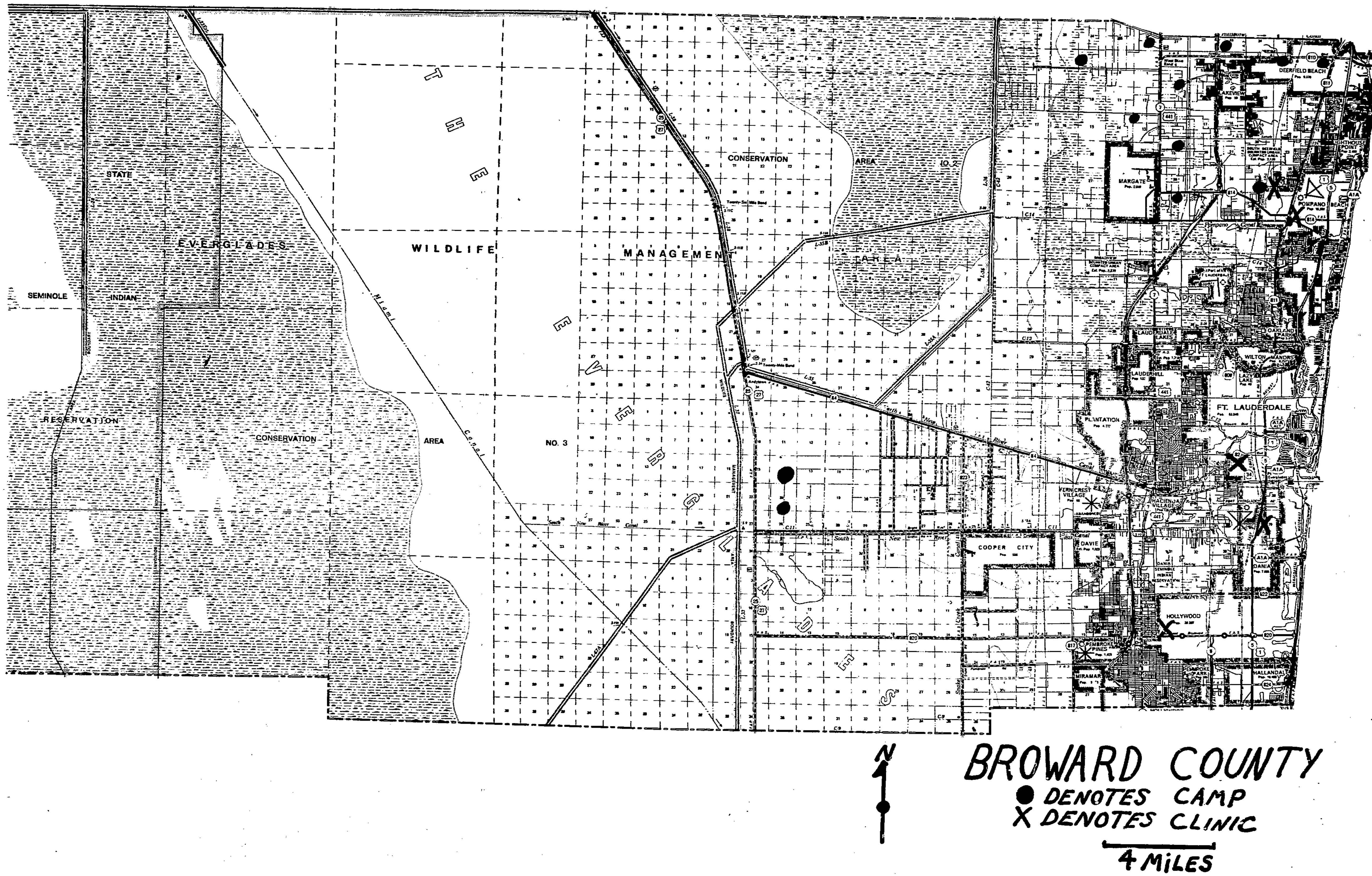
was unnecessarily spent in this direction. It is expected that both these defects will be remedied by new funds becoming available. At the same time, it is expected momentarily that a sanitarian will be assigned to the Project to work closely with the nurses and Project director, not only to conduct an inspection program of environmental sanitation, but more importantly, to conduct an active program of education in basic sanitation, safe food preparation, and personal hygiene.

It has already been noted that there is a trend for Broward County growers to move the base of their operations to Palm Beach County, while still retaining growing fields here. Several other trends have become evident, chief of which, is the extreme mobility of the migrant agricultural workers, even during the local growing season. Many of these workers, temporarily living in Broward County, may be recruited on a daily basis by the bus load to work in southerly Dade County or northerly Palm Beach County and at the same or different times other bus loads from other counties are being brought here. This operation seems to relate to the specialization that is developing among field hands so that some do only, for example, vegetable picking and others do only fruit gathering. During the 1963-64 season it was reliably estimated that there were about 8,000 migratory workers in Broward County while during the 1964-65 season now closing, the number has fallen to about 5,000. Aside from other possible reasons already noted, the chief factor seems to have been the bizarre weather experienced this season which was reported as unseasonably warm and dry so that crops matured at the wrong time for markets, or were of poor quality which has meant loss not only to local growers, but diminution in the annual migration of field workers to this county. Another significant trend is the apparent desire of the migratory workers to move into town instead of residing in farm quarters provided by the growers. This flow is into the poorer areas of Pompano Beach and Deerfield Beach where many existing problems in housing and sanitation are aggravated by this additional population. The true migrants in their new environment take on the coloration of the previous residents of these areas who comprise a large element of the Broward County

indigent population. These resident indigents often take field work in "season", working alongside the true migrants and distinguishing features are lost to the end of the season when the true migrant departs for the North. In addition, a fair number of migrants settle down in Broward County, leaving the annual migration to become part of the local free-floating indigent population which further complicates the picture.

Another interesting aspect has been the degree of community contribution stimulated by the presence of the migrant program. While formal commitment has not developed, in most cases, there has actually been a sizeable contribution by various elements of the community.

We are satisfied that the migrant medical clinic renders a primary and badly needed service. Our only dissatisfaction up until this point is that we have been unable to operate this clinic more than two afternoons and two evenings a week. We propose, with the help of an expanded budget, to render service in the second Project year extending to five afternoons and five evenings a week. Besides increasing clinic services, it is going to be necessary to amplify the field services by the public health nurses. An accelerated flow of patients to the clinic will result when the nurses make personal contact with the migrants in the field and the home and direct them to the clinic.



THE EVERGLADES
CONSERVATION AREA NO. 2
WILDLIFE MANAGEMENT AREA
CONSERVATION AREA NO. 3
EVERGLADES STATE CONSERVATION AREA
SEMINOLE INDIAN RESERVATION
Miami Canal
DEERFIELD BEACH
POMPANO BEACH
MARGATE
LAUDERHILL
WILTON MANORS
FT. LAUDERDALE
PLANTATION
COOPER CITY
DAVIE
HOLLYWOOD
MIRAMAR
N
BROWARD COUNTY
● DENOTES CAMP
X DENOTES CLINIC
4 MILES

UPPER LEFT: Broward mobile clinic brings the health department practically to the migrants' door.

UPPER RIGHT: This camp, with a capacity of 950, provides a clinic building for afternoon and evening health services for migrants in the camp and the surrounding area.

LOWER LEFT: Most migrants are paid at the end of each day's work. Tomorrow they may be employed hundreds of miles away.

BROWARD COUNTY MIGRANT PROGRAM

FAMILY HEALTH SERVICES CLINIC

Operation Jan. 10, 1965 through May 19, 1965

1. Total number of patients seen by nurse only: 238
2. Total number of patients seen by nurse and physician: 541
3. Total number of patients seen: TOTAL 779
4. Number of patients by condition:

Allergy	3	Skin	41	GYN	28
G.I.	41	Dental	8	Trauma	42
U.R.I.	184	V.D.	15	Neuro.	28
G.U.	18	Mat.	20	Immuniz. & No disease	222
Tumor	9	C.V.D.	78		
EENT	12	Orth.	5	N.P.	1
Arthritis	3	T.B.	8	Int. Parasites	12

TOTAL 779

5. Number of patients by age and sex:

	Under 15 yrs	15-44 yrs	45 yrs and over
M	203	94	114
F	175	116	77

TOTAL 779

6. Basic schedule:

2 - 4 P.M. Tuesday and Thursday
6 - 8:30 P.M. Monday and Wednesday

7. Total Clinic sessions: 69
Total weeks: 19
Total hours: 166½

COLLIER COUNTY HEALTH DEPARTMENT

C. L. Brothers, M.D., Director

Area of County: 2,032 sq. mi.

Resident Population: 22,000

Number of Migrants: 11,800

Migrant Project Staff:
1 Public Health Nurse
1 Sanitarian
1 Equipment Operator
1 Dental Assistant
1 Health Educator (part-time)

Period covered in this Report: September 1, 1964 - April 30, 1965

COLLIER COUNTY

Migrant Situation

The county agricultural agent reports that approximately 5,300 migrant workers were in the county at the peak of the "season". About 6,500 had been expected. Lack of adequate housing probably accounts for the decrease below expectations.

Accompanying the workers were approximately 6,500 non-working family members, making an estimated total of 11,800 persons eligible for outpatient medical services under Project M.

Ethnic backgrounds were roughly as follows: 30% Texas-Mexicans; 25% Caucasian; 25% Negro, and 20% Puerto Ricans.

Arrivals started about October 1, 1964, and a big majority had departed by June 1, 1965. A majority come from the Atlantic seaboard states, but a scattering come from Texas, Ohio, Michigan, and Wisconsin. As a rule, they depart for those states in the same proportions.

Approximately 50% of those present during the past season consider Immokalee as their home area.

There are 96 camps ranging from 15 to 400 occupants in the Immokalee area. Of these, 77 were permitted, and 19 operated without permits. Ten were permanently closed. There are 13 new camps that will be permitted next season.

There is one camp in the Naples area, and six in the Everglades area.

As stated above, shortage of migrant housing is an acute situation, and will continue to be so for the foreseeable future. Many of the unsatisfactory camps could not be closed because of the housing shortage. No off-shore labor is used in this area, and the crops grown do not lend themselves to mechanization at harvest time. Principle crops are tomatoes, watermelons, cantaloupes, peppers, squash, eggplant and corn. Some land in the area is being planted in citrus.

Family Health Service Clinics

CLINIC SCHEDULES:

Naples - Health department clinic every Monday, 8:00 A.M. to 5:00 P.M., including chest x-rays at health department. Naples Community Hospital emergency room 24 hours a day, every day.

Immokalee-Health department clinic Monday, 8:00 A.M. to 5:00 P.M., including Nursing Clinic, sick calls and home visits. Tuesday, 8:00 A.M. to 5:00 P.M. School Health, sick calls and home nursing visits. Wednesday, 8:00 to 12:00, Medical, prenatal, post-natal and well baby, 1:00 to 4:00, Medical and V.D. Thursday, 8:00 to 5:00, Immunizations, family planning, sick calls and home visits. Friday. 8:00 to 5:00, sick calls, school health and home visits.

Everglades- Health department clinic Monday, 8:00 to 5:00, School health, sick calls and home visits. Tuesday, 8:00 to 5:00, Nursing Clinic, including sick calls and innoculations. Wednesday, 8:00 to 5:00, school health and home visits. Thursday, sick calls, home visits. (Third Thursday each month, Medical Clinic in P.M.) Friday, School health, home visits and sick calls.

Starting November 2, 1964, evening clinics were held every Monday in the Immokalee area. In attendance were a physician, one or two nurses, a clerk and clinic-aide-interpreter. Clinic was scheduled to operate from 7:00 P.M. - 9:00 P.M., or until last patient was seen. The clinic schedule was announced in local paper, on radio and by home visits by nurses. The largest number to attend any scheduled clinic was six, and the smallest was three. In many instances, patients seen by nurses during that day were requested to return at 7:00 P.M. to be seen by the physician. None of these patients returned as requested. Obviously, the evening clinics were not economically sound with such scant patronage; they were therefore discontinued at the end of December.

The Everglades Clinic is staffed full time by a public health nurse. The health director holds clinic there one day per month, and is on call for additional visits as required. The number of persons qualifying for Project M aid is very small in this area.

The Naples clinic is manned five days a week by: the medical director, two full time nurses, two part time nurses, three sanitarians, one half-time psychologist, one full time mental health worker, three clerks, and a part time health educator. The professional people in this group make regular visits to other areas of the county. As in the case of Everglades, there are few Project M clients in this area.

The Immokalee clinic is staffed by two full time and one part time nurse, one sanitarian, one clerk, one clinic aide interpreter, and a part time physician. A large majority of Project M clients reside in this area. Patients who are in need of medical attention are given referrals to private physicians of patient's choice. These referrals are made by public health nurses or by the director. Patients who go without referrals to the Naples Community Hospital are treated by the physician on call in its emergency room. If the patient is thought to qualify under Project M, an "after the fact" referral is sent on to the health department, where a final determination is made as to eligibility. Some of the Naples physicians present bills for their services, but many do not.

During the period of this report, 670 referrals were made to physicians, including 85 seen in the emergency room. Approximately 200 patients were treated in our clinics with drugs donated by physicians, drug manufacturers, and civic organizations. A total of 73 were treated in our clinics for venereal diseases.

Our dentist performed 1,141 dental procedures (fillings, extractions, fluoride treatments) on 414 elementary school children of migrant parents. These numbers would have been much higher had we had our bus for the entire school year.

Nurses and other professional personnel made 1,033 home visits in connection with such matters as communicable diseases, venereal diseases, tuberculosis, pre and post natal care, child health, chronic diseases, mental health, health education.

During the period, 949 immunizations against smallpox, diphtheria, whooping

cough, tetanus, polio, and typhoid were given. About 95% of these involved Project M clients.

Six cases of active tuberculosis were admitted to state hospitals. One hundred and twenty-one patients were admitted to maternity service, involving 388 antepartum and postpartum visits to clinic and 324 home nursing visits.

Family planning devices, mostly contraceptive pills, have been supplied to 133 women.

Three hundred and fifty-five first grade school children were examined by the director and those with defects were referred to appropriate agencies. Defects included a congenital heart lesion, several hernias and one case of acute rheumatic fever.

Twelve cases of cancer were diagnosed and referred to tumor clinic in Miami.

Six cases of diabetes were diagnosed and given appropriate therapy.

Free chest x-rays are available for all tuberculosis suspects.

Several children requiring multiple tooth extractions under general anesthetic were referred to a local dentist under Project M. Many cases of periapical abscess involving older children and adults were also referred.

Prior to institution of this program, the work load largely prohibited routine home nursing visits for antepartum patients. Now these visits are routine and frequent, and results have been most gratifying. The nurses have instructed patients in such matters as diet, personal hygiene, environmental sanitation, protection of food from insects, flies, and rodents, and post-natal care of infants. Improvement has been noted in personal hygiene and nutrition of mothers, and in the condition of most infants, postpartum. Two cases will serve to illustrate the extremes of the problem. Project nurse reported Case No. 1 as follows: "My first home visit was to a 3 months old infant who had been hospitalized in Naples with diagnosis of dehydration, malnutrition, and gastroenteritis. The family of five lived in a one-room,

condemned camp shack with two single beds and a hammock for the baby, two-burner kerosene stove, no refrigerator or other conveniences. Living conditions and sanitation were deplorable, so I tried to teach her in regular home visits and in clinic visits. I provided an improved crib (box) and demonstrated baby bathing, formula preparation, sterilization of water, bottles and nipples, general home cleanliness. The mother was of such low intelligence that she could not seem to comprehend. Each time I went to the house it was filthy in all manner and polluted with flies from lack of screening and garbage strewn about the doorway. The mother was started on birth control pills, but she failed to cooperate and she became pregnant again. The baby was given four referrals under Project M for "URI", persistent vomiting, otitis media, and "intestinal virus". The mother left the baby with a baby sitter, who took no better care of the infant than the mother. The mother worked in the fields and saved enough money to enable her to fly to Puerto Rico to see her mother in March, so I learned from that, that she was able to do what she had determination to do and saw value in."

Case No. 2 was reported as follows: "One of the maternity patients was presented to me as a challenge. She was of low mentality, and had no formal education. She had ten living children, only one married, and was pregnant for the 14th time. They lived in a four-room cement block apartment, with conveniences, in a big camp. I tried to teach her better sanitation, hygiene and home making. She responded in a remarkable way. She was given materials and made baby blankets to prepare for the new arrival. She sorted her boxes of clothes and hung the dresses on hangers as advised. She re-arranged her furniture and had the beds in two bedrooms instead of in the kitchen. She scrubbed her floors, and picked up the trash outside. She got a baby bed on a stand to keep the baby safely away from the other children, and covered it with a net to keep the flies off, as instructed. She organized her children to help with chores and tidiness. She came to clinic regularly for pre and post-partum care. At postpartum examination she was found to need perineal repair. Vocational Rehabilitation is providing the surgical assistance, and

plans are underway for her to have a hysterectomy this summer."

Iron preparations are provided free of charge to all maternity patients who need them. Both adult and baby vitamins are provided at wholesale cost or free if the family cannot pay.

Nursing Services

Much of the information under this heading has been covered under Family Health Service Clinics. As stated, there are six full-time and one part-time nurse in the department. The six public health nurses are paid Florida Merit System salaries, and the part-time nurse is paid by the Naples Visiting Nurse Council.

Visits to camps by nurses were made on a case basis (Acute illness or injury, pre and postpartum, etc.). Size of staff did not permit regular visits to all camps. Policy was established that nurses would make a home visit on all cases involving diarrhea and dystentery in children. During these visits, efforts were made to upgrade the environmental sanitation and personal hygiene of the family members. In some such instances, the sanitarian accompanied the nurse. Prior to this Project, such visits were the exception rather than the rule. Numbers of visits are reported in another section.

All persons seen in clinics were given PHS Form 3652, Personal Health Record, and all prenatals not delivered before departure were given photocopies of their maternity records. They were also counseled about seeking medical help upon arriving at their destinations.

As part of the school health program, as many as could be induced to send stool specimens to the laboratory were screened for intestinal parasites. Several hundred specimens were sent in, and 33% were infested with one or more of the following: hookworm, ascaris, tapeworm, H.Nana tapeworm, and pinworm. The ascaris and roundworm cases were treated in clinic and the tapeworm cases referred to private physicians. To date, no drug effective against the H.Nana has been found.

Visual and audio screening is done yearly on selected grades in the schools.

Tuberculin skin testing is done in a similar manner.

Following is a listing of services available through the health department and other agencies:

PREVENTIVE:	Cancer Cytology, Chest X-ray, Child Spacing, Health Appraisal, Immunizations, Nutrition, Prenatal, Postpartum
CURATIVE:	Diabetes, Intestinal Parasites, Rheumatic Fever, Tumor Clinic, Tuberculosis, Venereal Disease
REHABILITATIVE:	Crippled Children, Vocational, Council for the Blind, Lions Club

Notable was a marked diminution in the number of cases of impetigo and other dermatoses during the past migrant season. Several factors contributed to this. First, overall improvement in the sanitation of living areas through the joing efforts of the nurses and sanitarians. Seoond, improvement in personal hygiene, and finally, a drastic reduction in the population of mangy, flea-infested dogs by a program of licensing of dogs and impounding and destruction of those not licensed.

While the incidence of diarrhea and dysentery continued at a high rate, the number progressing to severe dehydration and pneumonia was markedly reduced. This is attributed to early diagnosis and treatment, made possible by Project M. During the 1963-64 migrant season, eleven infants died in the Naples Community Hospital from this complex of diseases. During the 1964-65 season, only one such death occurred, in an infant untreated prior to admission.

Elementary school children were screened for pediculosis, and many cases treated. Mothers were taught to use DDT diluted with talcum powder.

One of the factors contributing most to the success of the program was the availability of a nine-passenger bus and driver, provided by the Project. Since the bus was delivered in January 1965, a total of 148 indigent patients were transported to tumor clinics and other clinics in Miami. Project M supplied 32 of this number. By having this means of transportation available, we are able to provide many services not available in this community; services which can be secured only in a metropolitan setting. When not in use for trips to

Miami, the bus transported 117 elementary school children to Naples for dental treatment. All of these children qualify under Project M. Three Project M patients were transported to state tuberculosis hospitals. Fifteen Immokalee patients were transported to the local clinic. To date, the speedometer shows a total of 20,957 miles, indicating full usage.

Nursing services were somewhat handicapped by the fact that we had only one clinic aid-interpreter. Many of our clients speak and understand only Spanish, and none of the nurses know this language. It was therefore necessary for the interpreter to accompany nurses on home visits to Spanish families. At the same time, the nurses in the clinic had need for an interpreter, and they had to wait until the one interpreter returned from the home visits. This resulted in great inconvenience to patients and nurses. If the Project is to be continued, an additional clinic aide-interpreter should be provided.

Sanitation Services Related to Migrant Housing and Work Locations

There are three part-time and one full-time sanitarian working on matters pertaining to migrants. All are paid salaries set by the Florida Merit System.

See map for locations of camps, mostly in the Immokalee area.

Standards for evaluating camps are provisions of the Florida Sanitary Code. A labor camp is defined as any camp occupied by fifteen or more persons.

A total of 571 visits were made to labor camps to check on water supplies, sewage and garbage disposal, fly and rodent control and correction of nuisances. Seventy-seven camp owners were granted permits. Owners of 15 of these camps were notified that major improvements must be made before they would be re-permitted. Ten camps were permanently closed, and 19 operated though not permitted. There was a shortage of approximately 2,000 beds in the county for migrant labor. It was found necessary to set up bunk houses in empty stores and other available shelters. Many workers had to be transported to other towns for rooms.

There are no public water supplies or sewage systems in areas where camps are located. Contamination of wells by septic tank effluent was a frequent occurrence.

Private capital is being encouraged to provide modern labor camps with approved sanitary facilities, including a bath in each unit. Recently constructed were 82 modern rooms with 30 baths. Twelve of these rooms are for single men, and 70 are for families, all with private baths and cooking facilities. Building plans have been approved for 68 additional rooms, all with baths. Also now existing or planned are four separate trailer camps with a total of 27 trailers, all with baths.

Most growers provide no sanitary facilities in the fields for the stated reason by them that such facilities, when available, are little used. Water is carried to the fields on the labor buses, and soft drinks are sold by the labor leaders.

Attitudes of camp owners varied from complete cooperation and understanding to complete indifference. On an average, general sanitary conditions showed a gratifying improvement, and there is in evidence a growing concern on the part of responsible members of the community for the plight of migrants as related to housing. Applications are now being prepared for assistance from the Office of Economic Opportunity to provide a central water system for the concentrated areas of migrant labor housing.

An editorial in the May 27 issue of the Immokalee Bulletin bestowed high praise upon our Project sanitarian for the fact that no serious fly infestation occurred in the area during the harvest season, in contrast with several infestations in past years. This was accomplished by daily inspections of watermelon sheds, canning plants and loading areas, and by prohibiting dumping of unusable produce in pastures adjacent to the town.

Crew leaders were encouraged to act as sanitary monitors for their camps, and some progress was noted in this area.

Most of the growers exhibit little or no interest in the migrants except as sources of necessary field labor. The growers deal only with crew leaders. One notable exception was one grower who constructed a large modern labor camp, complete with baths, sewage system, water, kitchen and mess hall. It is hoped

that the economic facts of life, such as a labor shortage during the last harvest season, will ultimately result in actions to provide adequate and decent housing for migrants.

Several visits were made to fields in company of owners in the interest of safe handling and use of toxic insecticides. The health department cooperated with the county agent and insecticide manufacturers in sponsoring a contest among the growers for maximum safety in handling and use of chemicals.

Health Education Services

There is one part-time, trained public health educator who has been working with the Collier County Health Department staff since February 1, 1965. The time is shared with Lee, Glades, and Hendry counties. For the purpose of this report, activities pertaining only to Collier County will be described.

Health education focuses on improving health attitudes and behavior of individuals and/or groups. It was decided that the prime groups to receive direct concentration at the outset would be three...Latin, Negro, and Anglo migrants. Other groups (growers, landlords, general public, etc.) would receive attention as a result of association with the former.

Before service can be successfully offered to a group, certain things must be known about that group. Therefore, health education activities have been limited to studying basic knowledge, attitudes, values, cultural traditions, and social structures of the three prime target groups. As a fringe benefit, favorable relationships have been established with church groups, school principals and board members, day care centers, county offices, voluntary agencies, individuals, and fellow staff members. The latter was the most difficult to achieve, due to the phenomenon of resistance to change or fear of an alteration in the modus operandi.

Health Education service in the form of consultation has been given to staff members in regard to certain aspects of their programs...presenting sex education material in the schools, teaching the relationship between flies and disease to illiterate Latin migrant families, selecting audio-visual materials.

The health educator served as consultant to a community group investigating the possibility of applying for Economic Opportunity Act funds.

As a health education service to the health officer and nursing staff, a pamphlet on personal hygiene was developed.

It is premature to discuss effectiveness of the educational effort, as it has been confined to information gathering, becoming acquainted with the community, and with limited consultative services. However, it can be assured that the preliminary steps now being taken will contribute to the success side of the scale in programs planned for the coming year. Likewise, it can be assured that the limited time allowed for Collier County will hinder the productivity of the educational effort.

One barrier to education with Latin migrants is language. In an effort to overcome this, the health educator is taking Spanish.

Plans are underway to conduct a community improvement project in the Negro section of Immokalee this summer. This will be an "involve the people" project. The stationary residents involved during the summer will provide the nucleus for continuation of the program in the fall, when the season people return.

There will be an increased emphasis to provide educational experiences accompanying clinic programs. A slide series is being developed depicting child care, prenatal care, nutrition, etc., which will be appropriate for use with the three migrant groups. Demonstrations and displays will be used in conjunction with group discussions as a part of the clinic program. Methods of presenting information will be reviewed and refined.

It is obvious that night programs must be started to reach the working people, particularly the males who have been ignored to date. Groups and program content will be flexible to adjust to interests of the people.

School health will be given more emphasis, in order to establish some continuity of health services and education programs during the year, and from year to year. Preschool planning sessions and periodic meetings of educators

and health department staff will be held to initiate and check the progress of the school health program. Again, health department staff will have to be flexible to be effective.

Regular staff meetings in Immokalee have been established to afford personnel the opportunity to discuss together the progress, problems, and suggestions for the overall migrant health program in the area. This in itself will be an educational experience for the staff, and will provide an opportunity for in-service training activities.

In summary, the health education phase of the migrant health program is in its infancy in Collier County, and does not lend itself to meaningful appraisal at this time. However, all indications point to its effective incorporation into the Project.

Other Items Pertinent to Future Project Development

The work schedule of the staff was so crowded that little time was afforded to make any sociological studies among the migrants. Operation of clinics, holding of sick call, making home visits, instructing patients in clinics and in their camps relative to sanitation, personal hygiene, nutrition, etc., was a full-time operation for all personnel. It has been noted that the older members of the families are least receptive to the idea of trying to improve their lot by their own efforts. Similarly, members of this group are incapable of absorbing instruction or are indifferent. School children and young adults offer the most fertile grounds for future efforts in education for a cleaner environment and in the pursuit of good health. Our plans are being made accordingly.

One of the factors militating against progress is the high rate of alcoholism among migrants. The county agent and state employment officer estimate that on any given day fully 20 per cent of the workers stay away from the fields due to drunkenness or hang-over. Every night is Saturday night, as each worker is paid for his or her day's work at the end of the day. Again, any hopes for the future lie in working with children and young adults.

Matters of cooperation involving migrants have been covered in other sections

of the report. In the community, many individuals and agencies cooperated with the health department in trying to help these people.

1. Members of the Collier County Medical and Dental Societies provided services at Welfare rates, and in many instances, at no cost to the Project. Estimated value of free services - $500.

2. Pharmacists provided drugs at state welfare rates.

3. Naples Community Hospital expended $750 for ambulance service to Miami for seriously ill or injured migrants.

4. Naples Community Hospital provided hospitalization for acutely ill and injured with full knowledge that they would not receive any reimbursement. This has caused a deficit in the hospital operating budgets. For the period of this report, hospital bills of migrants in the amount of $10,029.44 have been written off as "approved charity". The amount of $4,679.21 is carried on the books as bad debts. Very little of this is likely to be collected. During the calendar year 1964, 422 migrant patients caused a deficit of $68,394 in the hospital budget.

5. Physicians treating patients in hospital did likewise. The exact dollar value of these services is not known, but would amount to approximately $16,000.

6. The Immokalee Migrant Committee expended $917 to buy food, clothing and other necessities for the destitute.

7. The Lions Club expended approximately $100 for glasses for needy children.

8. Naples United Church Women donated $500 for support of the Negro day nursery, and $100 to the health department for purchase of vitamins.

9. The Episcopal church women donated $25 for purchase of douche bags.

10. A lay group of women in Naples meets twice a week to sew for migrants making layettes, clinic gowns, drape sheets and nurses aprons. They pay for the materials which amounted to $300 during the past season. This group made and donated 75 layettes.

11. The Lutheran church women carry on a similar activity. During

this past season they made and donated 25 layettes and 50 little girls' dresses at a cost of approximately $200.

12. The Presbyterian women's group donated $150 for clothing for migrant children.

13. The Mennonite church operates a day nursery for children of working mothers. This group performs acts of charity too numerous to mention.

14. School officials have been most helpful in rounding up volunteers to transport school children to the dental clinic in Naples, and return. Dental Services worth $4,564 were provided by the health department to 414 children of migrant parents.

15. The many agencies in Miami have performed many valuable services for migrants at no cost to the patients. Among these are: Cancer Clinic of Mt. Sinai Hospital; Vocational Rehabilitation; Crippled Childrens Commission; Variety Childrens Hospital; Council for the Blind; National Childrens Cardiac Hospital; and many others. We have no way of estimating the dollar value of these services, but would estimate that it would exceed $25,000.

16. Collier County Welfare paid $3,203.60 for burial of deceased migrants.

17. Collier County Mental Health Association paid for five E.E.G.s at the anti-convulsant clinic at a cost of $100.

18. Collier County Cancer Society donated $1,200 to defray operating costs of the bus used in transporting patients to clinics.

19. Collier County Welfare expended $2,134.20 for hospitalization of two seriously ill migrants in Jackson Memorial Hospital in Miami; one case was a dissecting aneurism of the thoracic and abdominal aorta; the other was basiler skull fracture and multiple brain contusions. The agency also expended $876.40 for hospitalization of migrants in State tuberculosis hospitals. Transportation to other states of disabled migrants are also paid for by this agency in the amount of $478.

20. Private citizens donated $502 to purchase furniture and clothing for two migrant families whose duplex burned to the ground.

No individuals or groups were obstructive to the Project.

As noted under Nursing Services, the language barrier presented problems

which were only partially solved. An additional clinic aid-interpreter is an absolute necessity if the Project is to continue. An additional nurse is needed.

The administrative and clerical staffs of the department were not augmented in any way, hence Project M has caused an added work load to personnel in those sections. Record keeping has been kept as simple as possible, commensurate with sound accounting practices. This and other projects have increased our work load to the extent that we have outgrown the Immokalee clinic building, originally designed for less than half the current clientele. The Board of County Commissioners have stated that our clinic will be enlarged in the near future.

The only changes made in the starting date of the Project were dictated by higher eschelons of command. We were prepared to start as originally scheduled. Operation of the Project plan has not been changed, as this plan has operated to the satisfaction of all parties concerned. A dental assistant has not yet been employed due to lack of clearance on this position by a state agency.

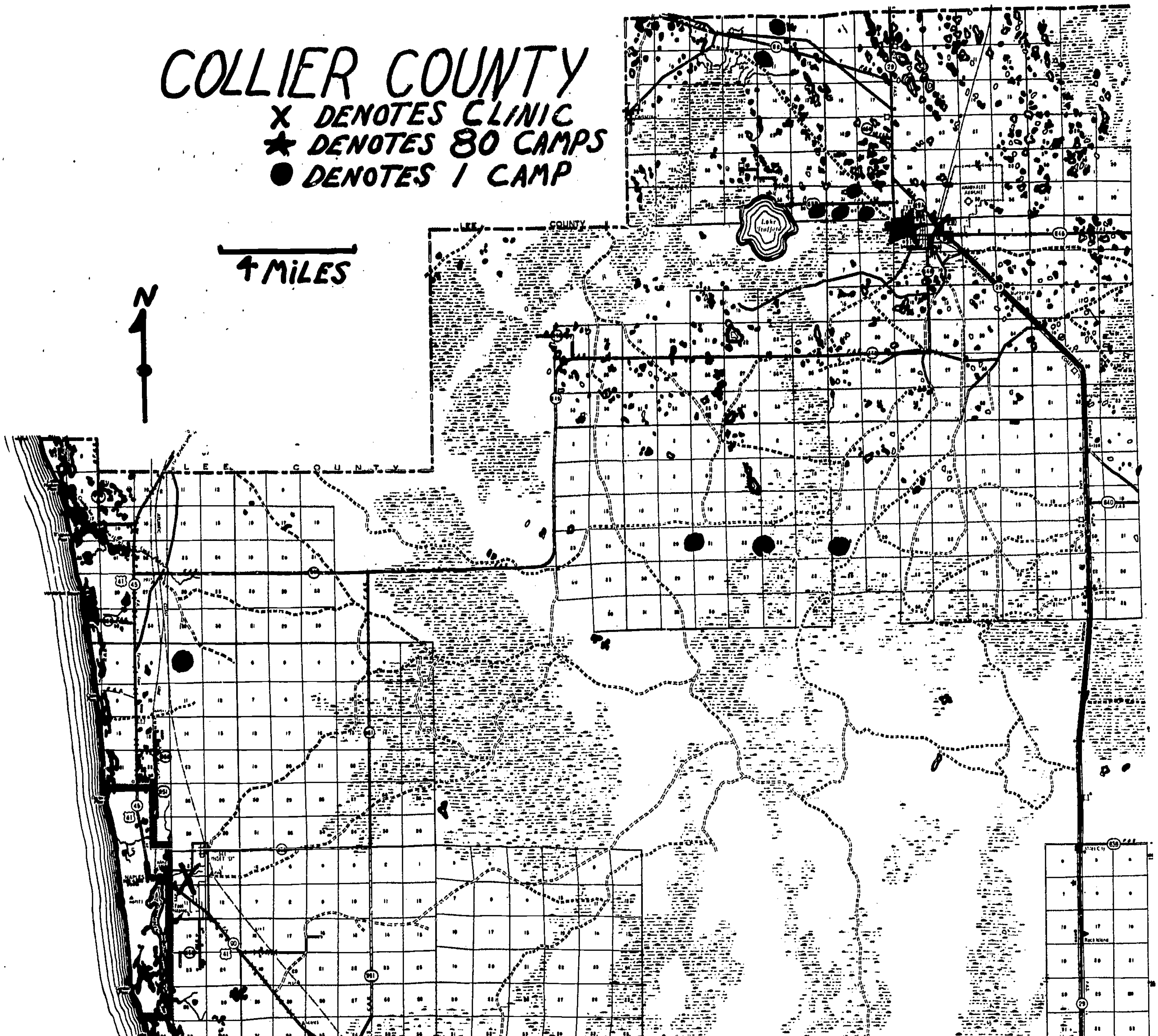
Major success of the program was provision of medical diagnosis and treatment not available in prior years, or available only in limited quantity, with resultant reduction of morbidity and mortality. Associated with this are improvements in the sanitary environments of migrants, improvement in personal hygiene, and progress in health education. As one Project nurse stated in her report, "The greatest accomplishment has been to be able to give some service to every person visiting the department."

The major shortcomings were the results of ignorance and indifference; ignorance on the part of the clientele, indifference on the part of clientele and some members of the community. The only solution to these problems is a long-range one, education.

The Bureau of Maternal and Child Health of the Florida State Board of Health provided assistance in many ways. Salary and travel of a full-time Public Health Nurse III are paid by the Bureau, and salary of a part-time Public Health Nurse

III also. The Bureau also pays salary of a clerk and clinic aid-interpreter. MCH provides many drugs used in the clinics, including family planning materials. Other bureaus of SBH provide vaccines, rheumatic fever drugs, insulin, antibiotics, anthelmintics, etc. Collier County provides clinic buildings, plus salaries and travel of other personnel in the department who augment the Migrant Project. This support will continue in the future as it has in the past.

Most data for reporting purposes were provided by clerical staffs in Naples and Immokalee clinics. Other data were obtained from many sources. It is believed that data collected and presented are adequate to justify continuing the Project on an indefinite basis.


COLLIER COUNTY
X DENOTES CLINIC
★ DENOTES 80 CAMPS
● DENOTES 1 CAMP
4 MILES
N
LEE COUNTY
LEE COUNTY
COLLIER SEMINOLE STATE PARK
EVERGLADES

Value of prenatal examination of migrant women is stressed by Collier Health Dept. Too many migrants do not take advantage of clinic services available to them.

The public health nurse spends much of her time visiting labor camps. Several nurses are studying Spanish in order to communicate more effectively.

This small bus is used, among other things, to transport migrant patients to facilities outside Collier County for specialized treatment. It has rolled up 21,000 miles since it was delivered four months ago.

When this camp is completed, it will be Collier County's hundred and third migrant camp. The county was short an estimated 2,000 beds this season. The sanitarians stay busy in Collier County.

HIGHLANDS, GLADES AND HENDRY COUNTY HEALTH DEPARTMENTS

William F. Hill, Jr., M.D., Director

Highlands County

Area of County: 1,041 sq. mi.

Resident Population: 22,000

Number of Migrants: 3,000

Glades and Hendry Counties

Area of Glades County: 746 sq. mi.

Resident Population: 3,200

Area of Hendry County: 1,187 sq. mi.

Resident Population: 10,600

Number of Migrants (combined): 8,000

Migrant Project Staff:
1 Public Health Nurse
1 Sanitarian
1 Clinic Physician
1 Clerk-Typist
1 Health Educator (Part-time)

Period covered in this Report: September 1, 1964 - May 20, 1965

HIGHLANDS, GLADES & HENDRY COUNTIES

This Project Area was designed to follow the same geographical area as the Tri-County Health Unit of Highlands, Glades and Hendry Counties. The crops are quite varied in this area. Highlands is mainly a citrus area, with some caladiums. Glades and Hendry have large sugar cane and sod acreage, tomatoes, green peppers, cucumbers, watermelon, beans and cabbage. Additional crops this year were celery, potatoes, and cantaloupes. Hendry County will have about 50,000 acres of citrus in the next two years.

The migrant population is quite different in each one of these counties. In Highlands, with the exception of three multiple room barracks. the migrant population of 2500-3000 is completely assimilated into the county population. These are resident migrants, or out-migrants, and are mostly Negro. They work citrus in their own county and adjacent counties, and when citrus season is over, they migrate to the Carolinas, the Eastern Shore, or New York State. Due to this assimilation, the physical distances between counties, and concentration of Project staff in Glades and Hendry, the Highlands County staff has tried to extend itself mainly to identifying these people as migrant and giving services to them.

In Glades, there are two divisions --one assimilated and one camp-oriented. In the assimilated group we experienced the same difficulty as in Highlands, namely, asking every person whether or not he migrates. The camp population in Glades consists of offshore labor and medical services are provided by contract; however, a full range of preventive and referral services is available to the contract medical officer. Any other migrant identified was eligible for all services offered in the Project and any other service, local or state, on the same basis as county citizens.

In Hendry County the Farm Migrant population lives almost entirely in camp housing. Again, there is a large group of offshore labor and a larger group of in-migrants. This is in contrast to Highlands and Glades. These people migrate to Dade and other Florida counties, then finally to Michigan or Ohio. With the

expansion of agriculture in this area and the prospect of no offshore labor next year, the population to be served should grow in numbers and within that number, more people will need service because of loss of contract medical services for offshore labor. A concentrated effort must be made in Highlands and Glades to identify the service population. There are three main ethnic groups - southern Negro, Spanish speaking peoples (Puerto Ricans and Mexicans), and offshore Negro. The migrant population in Glades and Hendry is 7000-8000. The sources for the estimated figures are as follows:

1. Florida Fruit & Vegetable Growers Assoc., Belle Glade
2. U. S. Sugar Corporation, Clewiston
3. Florida Employment Service, Winter Haven & Belle Glade
4. County Agents, Project area
5. Growers, Project area

Sanitation services are rendered to the migrant population regardless of point of origin. As stated above, there are numerous small and large camps, housing groups of migrants as well as the necessary general sanitation services in the assimilated areas.

Sources of service other than Project funds include State Tuberculosis and Mental Institutions, Crippled Childrens Commission, Vocational Rehabilitation, Tuberculosis Associations, Cancer Society, National Cardiac, Lions Clubs, County Welfare, Local hospitals, dental services in schools, free lunch program, and others as the need arises and arrangements can be made.

A full range of Public Health and Medical Care Services were available to the migrant population in the Project area. Service was rendered in excess of that which could have been rendered without the Project. Failure to find a health officer curtailed some of the planning and some of the planned programs. The Project public health nurse and the sanitarian were not employed until October 1. Based on the experience gained so far, the director believes that the Project needs two divisions, with personnel available to both. He believes one social worker is essential in identifying migrants, especially in Highlands, and helping the migrants in all Project areas to obtain services from local

sources, explain services in other areas, aid in referral and follow-up. He sees this as a short-term addition which would be picked up by local funds shortly. He believes nursing and sanitation services need to be immediately available and personnel full time should be assigned to Highlands County. The educational aspects through all personnel must be continued. The referral system in this Project area has been quite successful. The unique system for paying for out-patient medical care is worthy of continuation. This is similar to a third-party payor, except the patient is billed for two consecutive months so that he can exercise his own responsibility. Any payment made is deducted from the total bill before submission to the Project. We have processed several bills which indicate success in this trial program. This program will be extended to Highlands County with better identification of migrants and their families. The director believes the use of health aides, similar to the Seminole Indian Program, would be of benefit in accomplishing the planned objectives.

Sanitation Services

One sanitarian is assigned to this Project in Hendry and Glades Counties. At the beginning of the 1964-65 season, there were no camps which fully met the State Board of Health Standards. There were 193 visits made to nineteen camps during this season. Of these widely scattered locations in Hendry and Glades Counties, ten camps were licensed, four did not meet minimum requirements and were disapproved, and three were inactive. Of the ten which were licensed, one was a consolidation of three camps -- Frierson, Moore and Click -- which incorporated to form Click Farms, Inc. The Campbell and Gaunt "Tent Camp", located south of La Belle in Hendry County, continually violated the camp code and has been given notification of elimination. Plans are now being made for a new camp for the coming season.

To date, there are no definite laws governing migrant housing outside of camps. This is becoming a problem both in Hendry and Glades and some planning has been done to activate a check on these areas, which are usually found in the lower income sections of La Belle, Clewiston, and Moore Haven. Migrants tend to congregate in these areas due to unemployment and/or lack of housing

in the designated labor camps. To alleviate this problem, plans have been drawn in cooperation with city officials for future action. Some housing has already been condemned where migrants would normally stay.

A well survey was conducted before camps were licensed. Of the ten water systems surveyed, four were found to be contaminated. These wells were chlorinated and checked until found free of contamination. Supplementary samples were taken regularly to ensure potability. Water, which was trucked to the fields, was sampled and some found to be contaminated. Education in the proper cleaning of containers on a daily basis is gradually eliminating this problem.

Many aspects of safe water supplies and sewage disposal have been taught to the growers, thus allowing the sanitarian to devote more time to other areas of sanitation.

The problem of many violations is due to the fact that many growers do not know what to do about a given situation. Education in this field will relieve the sanitarian of many petty problems. For example, if a grower receives a contaminated water sample, he knows immediately what to do. One grower, upon receipt of several contaminated water samples taken from distribution points, though the well sample showed purity, put in a completely new water system.

There were several complaints of pests (lice, roaches, rats) reported to this department, which, in turn, were discussed with the growers. Barracks were fumigated by experienced pest control operators.

Food service may come from mess halls, common kitchens, or individual cooking. It has been noted that where the men do their own cooking, many sanitation violations exist.

A garbage and trash disposal problem is prevalent in 60 per cent of the camps, however, this is a result of the basence of a camp supervisor.

Many of the camp sites in Hendry County are located in low-lying areas, and, at times, high water creates a problem. This affects both the sewerage and water systems. More drainage ditches in these areas are planned for the coming year.

Most relationships of the sanitarian were established only with crew leaders and growers. This is for the purpose of obtaining corrections more speedily, gaining information, and conveying sanitary practices and ideas to the entire group of laborers. Sanitation group counselling was not instituted during this season, but is planned for our '65-66' schedule. Certainly migrants have problems, and interest in these problems can be created. The sanitarian did attend group meetings with nurses, health educators, and church groups, to exchange ideas and assist in those areas of concern.

The majority of improvements are made during the "off-season". When changes or improvements become necessary during the growing season, it necessitates a special trip to search the owner out in order to discuss the problem immediately. We realize the growers are very busy and have many problems with which to contend. Many of the growers have supervisors who are authorized to buy materials and make decisions, when needed. Many contacts between the sanitarian and the supervisors have been made to establish the trust needed to take care of necessary corrections. Many growers live in distant cities and must be contacted by telephone or mail, (depending on the seriousness of the violation). This becomes necessary in cases where a supervisor is unable to take action without the grower's authorization.

Sewerage seems to be the most important maintenance problem. Most migrants (as one grower put it) are "master-plumbers" and specialize in the flush-type apparatus. One laborer told the sanitarian that he liked to hear water trickling through the commode all of the time. Many camps lack urinals, and this migrant had pulled the components out of the commode to attain his desire. Further destruction is done to sewerage facilities because of drunkenness, disgust, and assorted other reasons. Many attempts have been made to correct such problems, but apparently to no avail. One example of such an attempt was to place a bar of wood or steel along the back of the commodes, and to lock it at either end to prevent entrance. This only resulted in broken locks. Plumbers and custodians have been hired full time for these jobs, and, on many occasions, the sanitarian found the problem and obtained the required correction. Many migrants

make proper use of their housing and sanitation facilities due to educational measures previously taken. Where housing and sanitary conditions are poor, one cannot expect to find much care on the part of the migrant inhabitants.

Certainly the growers realize that a certain amount of upkeep to facilities is necessary. If migrants are educated in the importance of maintaining sanitary facilities, they will see the good of the system and will wish to assist in caring for the facilities for their own benefit.

For the next year plans are being made to keep a paid supervisor in each camp, with possible deductions to be made from the pay of those persons found destroying property. The growers are in a peculiar position, for the migrant will leave for another job if too much pressure is put on him.

The fact that no major diseases were noted during the past season does not mean that improvements should not be made. Health hazards exist in some of the camps and arrangements for the future elimination of these violations have already been finalized.

As the end of the season approached, many growers show increased interest and cooperation in correcting violations and in improving living conditions for their workers.

We believe progress has been made, but violations still exist, with potential health hazards to be solved before the next season rolls around.

Nursing Services (Hendry)

During the agricultural season of 1964-65 the public health nursing program of the Migrant Health Project was conducted in most areas by a nurse assigned to the Project. Due to population concentrations and lack of supervised medical care, more service was offered at two labor camps known (in order named) as "The Tent Camp" in western Hendry County and "The S&M Camp #3, which is located in an unpopulated area about thirty-five miles south of Clewiston.

Occupants of the "Tent Camp" arrived in October, left the latter part of

December for crops further south and returned in February. The camp was virtually deserted by late May. Sanitary facilities (or lack of same) and descriptions of sites are discussed in the Sanitation Report. The tent camp might be described as extremely drab, with no recreational facilities and little to encourage the homemaker. Overcrowding was common, especially during April and the first two weeks in May. Mexicans, Negroes and Caucasians were scattered throughout the campsite and self-segregation was noted among certain groups. General Clinics were held every Wednesday from 10:00 A.M. until all who wished or would accept service and advice were seen. Migrant Health Service Index Referrals were used with a fair amount of success. Transportation to local clinics, referral agencies, and private doctors was always a problem for this group. The most successful solution found was to have the labor boss' mother provide the transportation and have the Migrant Project Fund reimburse her at the rate of 7½¢ per mile.

Several Planned Parenthood classes were held. It was interesting to note that even though the Negroes and Mexicans live in adjoining tents, they requested separate classes. Since much Spanish translation was involved with the Mexicans, this method proved more successful. Audience participation was good. As a direct result of these classes, 8 Papanicolaou smears were done by the local health officer at the La Belle Health Center and the patients started on oral contraceptives. In an attempt to achieve a higher degree of continuity of care for these patients, a "Personal Health Record" form (PHS 3652) was initiated. A report of the smear, name and dosage of oral contraceptive, date medication was prescribed and the physician's signature was included.

Tuberculin tests were given to 45 migrants, 40 were read and eight were found to be positive. Chest X-rays were ordered for all positive reactors by the health officer and the age limit for the mobile X-ray unit was lowered from 18 to 12 years of age for all migrants. However, many of these patients had moved south at the time of the X-ray unit's visit in January and Migrant Health Service Index Referrals were forwarded to their area asking for follow-up of positive reactors.

Also in the "Tent Camp" a problem was encountered which involved a group of male homosexuals who, after receiving adequate treatment for syphilis, were constantly reinfecting each other. The venereal disease investigator was unable to obtain any reliable information and the public health nurse's information was always indirect. Fortunately, several interpersonal relationships had been established between health personnel and migrants prior to the arrival of the homosexuals. This proved to be the only reliable source of information in attempting epidemiological investigation.

A classic problem in providing care to the migrant was encountered here. A ten year old Mexican female had a soft tumor mass on the dorsum of her left foot. Referral to Florida Crippled Children's Commission in West Palm Beach (some 100 miles distant) was recommended, but the family was leaving the next day. The name and address of our local health department was given to the mother. When she arrived at her next destination, she wrote to us and was advised to attend the nearest health department clinic in her area for this problem. A letter was also written, giving them the address of the local health department on the Migrant Health Service Index Referral identification slip. The result of all this effort is, to date, unknown.

At the S&M Camp #3, in the eastern end of the county, the migrants are primarily of Mexican origin and usually stay the entire season, which begins in October and ends in April or May. This is a more permanent camp consisting of frame wooden houses and a few trailers. Families are usually large and they tend to return year after year. The grower has done much to improve the camp in the last few years and at the beginning of this season, the health department was furnished a clinic building for the first time at the camp.

In October, a house-to-house census was taken in this camp with a young Mexican girl serving as volunteer interpreter. She proved to be an invaluable aid with introductions and the first attempts to establish rapport were made with moderate success. She also translated health posters and information and assisted with clinics. Another volunteer, for whom the health department had arranged the surgical repair of a hernia several years ago, painted the new

clinic building with a wood preservative.

Shortly after the census, a tuberculin testing program was conducted in conjunction with a school screening program done in the entire county. One hundred and one tests were given; 95 were read; and 24 were found to be positive. Four of these were 12 years of age or under. The mobile chest X-ray unit was utilized in January and 75 chest X-rays were taken, including 21 of the 24 positive reactors. No film reports of suspicious tuberculosis were received and only one film was returned for other pathology.

In this camp, general clinics were held every Tuesday afternoon from 1:00 until 4:00 P.M. In April, the clinic day was changed to Friday morning which enabled the health officer to attend. Attendance at these clinics was very good at first, but gradually began to decline. It was felt that one reason for the decline was the prenatal nursing clinic which had a very successful beginning in December. The first patient to deliver from this clinic had a healthy 7½ pound boy. The second clinic patient delivered prematurely and the other prenatal patients began to disregard their clinic appointments. A short time after the premature delivery, a third clinic patient's diagnosis was pseudosyesis and the dropout rate was almost 100 per cent. After an interval, however, several new patients were admitted to the maternity clinic and a few of the original patients returned.

Another reason for the decline in clinic attendance was thought to be due to disappointment or to anticipations unrealized. An assistant health officer was expected in December and plans for a night clinic with a physician in attendance were discussed, perhaps prematurely. Efforts to recruit this professional addition to the staff were fruitless; consequently, much of this discussion may have sounded like "lip service".

Most of the work done in both camps consisted of immunizations, tuberculin tests, chest X-rays, tests and treatment for intestinal parasites, general health education, infant care, formula preparation by demonstration, planned parenthood instruction (when and where acceptable) and prenatal nursing care.

Referrals were made to private physicians, Florida Crippled Children's Commission, the Tuberculosis and Respiratory Disease Association, the Anti-convulsive Clinic in Miami, and to our own health officer.

Migrant Health Service Index Referrals were used when adequate information was available. However, many migrants were unable to predict a specific location. Apparently, most of them enter the eastern seaboard stream, migrate to Michigan and Ohio for the cherry and strawberry seasons, or to Texas and Mexico. Some will return to their homes in the southern states.

Many of the migrants have been assimilated directly into the local communities and identification becomes a problem. They may be found in La Belle in both the white and Negro sections and the same may be said for Clewiston. For example, a Negro male, aged 55, was discovered in the Negro Harlem section of Clewiston with far advanced, active pulmonary tuberculosis. This man has been "in the stream" from New Jersey to Florida for the last eight years and had been residing in Clewiston for the last four months. He was quickly removed from this environment by hospitalization at Southeast Florida Tuberculosis Hospital. It is understood that residency laws prevent solution of this problem in many states.

Two small camps located southwest of Clewiston near the Collier County line were discovered late in the season and were not included in the program.

Another group, employed in agriculture who may be classified as migrants, are the Seminole Indians. They follow crops nearby and return to the Reservations when feasible. For many years, their medical care has been provided under another program and they usually prefer to attend the Reservation clinics where they are known and are familiar with the personnel.

A maternity clinic, which is held each week at the health departments in La Belle and Clewiston, is utilized by migrants from other areas who learn of the clinic's existence from various sources. These patients may live in the local community, at a U.S.S. C. Sugar Camp (Rita) located in Palm Beach County (but only two miles distant) or at Shawnee Farms in nearby Glades County.

The Following Suggestions were submitted by the PHN assigned to the Migrant Health Project:

1. I would like to have each county use a stamped post-card with the referring health department's address. If these were given to the patients with mailing instructions on arrival at next destination, I feel the Migrant Health Service Index Referral could be more successful. I have "lost" treatment on Migrants when they could not tell me where they were moving. I have also lost continuity of care when new migrants who arrived in our area had thought they were going elsewhere. Immokalee has sent several migrant referrals, but usually by the time I get the referral, the migrants have moved on. I have had some degree of success with the method and would like to have it tried on a larger scale.

2. The La Belle "Tent Camp" is in dire need of a day care center for the children. Several times infants were left in the tents for eight hours or longer with only an older child for supervision and care. A local resident in La Belle was very interested in this problem and was eager to help. This project seemed to bog down with preparation and was never started. I would like to see it organized and ready for service at the beginning of the 1965-66 season.

3. The completed Migrant Health Service Index Referrals that I received were frequently far from complete. For instance, on a Venereal Disease referral, the only information on the form stated that the patient was seen and referred to the VD clinic. This was of no help at all when the patient returned to my area. The same problem presented itself with a patient reported as having suspicious tuberculosis -- the only information on the referral stated that the patient was seen in X-ray clinic. I would like to suggest that the referral not be sent to the State Board of Health in Jacksonville until it is completed. An early incomplete return appears to be of little value.

4. As is true in all areas, night clinics are almost mandatory in order to reach the total migrant population. In the S&M #3 Camp, the migrant population was approximately 120. In the "Tent Camp" it was estimated at 350 during the peak of the season. A very small percentage was reached with our day clinics.

5. I would like to see every means used to encourage the migrant to assume responsibility for his own health. Our general clinic in La Belle (with Dr. Hill in attendance) is held the day following

the tent camp clinics. In many instances, these migrants were capable of getting to La Belle, and this was strongly encouraged.

6. A local transportation committee can be a great asset. They can be used to provide transportation to various clinics and referral agencies. Once the transportation committee is established, it should be used with as much regularity as possible.

7. I would like to see an area meeting of the different disciplines working with the migrants. Each area has its particular problems, but all of us encounter many of the same problems. I think comparing notes on how each of us tries to solve the problems would be beneficial to all concerned.

To summarize the needs and problems to be solved in the next year, the following comments are offered:

1. Improvement of communications.
2. Need for establishment of day care centers for children.
3. More complete information on forms already in use.
4. Need for night clinics to reach total migrant population.
5. Formation of transportation committees.

It is also felt that an alert, competent camp manager would alleviate many existing problems and prevent the occurrence of new ones.

Nursing Services (Glades)

As in Hendry County, many migrants are assimilated into the local community. However, there are several large labor camps which have been in existence for many years and their owners employ both domestic and offshore labor. In these camps, the inequity of medical provided is obvious. Offshore laborers receive medical care from contract physicians and hospitalization is provided. The domestic, although employed by the same grower, does not have this advantage.

The camps mentioned above are Benbow Village, Click and Chamberlain Farms, Glades County Sugar Growers Cooperative Barracks and Shawnee Farms. They are described in the sanitation report and have been under health department supervision.

Domestic residents of these camps are registered voters in Glades County,

yet the majority of them enter the eastern seaboard stream, usually returning from New York State before school opens in the fall. They are familiar with the services of the health department and although migrant personnel have not been specifically assigned to this area, they have received the same quality of nursing and medical service as in Hendry County.

Migrant Health Service Index Referral forms have not been used successfully because specific destinations are not known. Mexican crew leaders may state they are going to South Carolina to "work tomatoes" but they do not or will not tell the name of a nearby town.

All areas were covered by the mobile chest X-ray unit when a survey was made in January 1965. Welfare officials assisted one non-white male to return to Alabama after treatment for a lung condition was recommended by a local physician. Another non-white male, aged 52, was diagnosed as having active pulmonary tuberculosis and was transferred from a nearby hospital to the Southeast Florida Tuberculosis Hospital. He expired shortly after admission and an autopsy revealed death was due to other causes. In the follow-up of his contacts, a non-white woman living in the same trailer with him was found to be an old tuberculosis patient who had been discharged from a Florida hospital about ten years ago. She left the area before the follow-up was completed and her address has not yet been obtained.

The chief problem to be overcome in Glades County seems to be that of the identification of the domestic migrant and the establishment of his need for medical care. State agencies are utilized if possible, but there is a great need for more local resources. As a whole, the large camps are fairly well managed and do not require as much assistance as the "free wheelers" or members of a crew leader's group.

Health Education Services (Glades-Hendry Counties)

There has been one part-time, trained public health educator working with the Glades-Hendry County Health Department staff since February, 1965. Time is shared with Collier and Lee County, resulting in only one day per week

allotted to Glades-Hendry. This report is concerned with the latter two counties.

Health education focuses on improving health attitudes and behavior of individuals and/or groups. The prime groups selected to receive attention at the outset were the Latin and Negro agricultural workers and their families in the La Belle Tent Camp and the S&M Mexican Camp. Other groups (growers, landlords, general public, etc.) would receive attention as a result of association with the former.

Before service can be successfully offered to a group, certain things must be known about that group. Therefore, health education activities have been limited to studying basic knowledge, attitudes, values, cultural traditions, and social structures of the target groups. Also, time was spent becoming acquainted with facilities available in Glades-Hendry. As a result, favorable relationships have been established with church groups, civic clubs, individuals, and health department staff.

Health education service in the form of consultation has been given to staff members in regard to certain aspects of their programs -- working with people on environmental sanitation problems, explaining the physiology of conception and the use of contraceptive devices to Latin and Negro women, selecting and using audio-visual aids.

A large part of the health education effort (despite original plans to work mainly with migrants) has been directed toward forming a broadly-based Community Migrant Committee. Success is questionable in terms of organization, but much has been learned in regard to community knowledge and feeling about migrant agricultural laborers. Good working relationships have also been developed. In addition, it is probable that a working committee will be formed by late fall.

One bit of information reported by a nurse that may or may not have health education significance is that bilingual, literate migrants are offended if asked to read material in Spanish. They feel they are being called

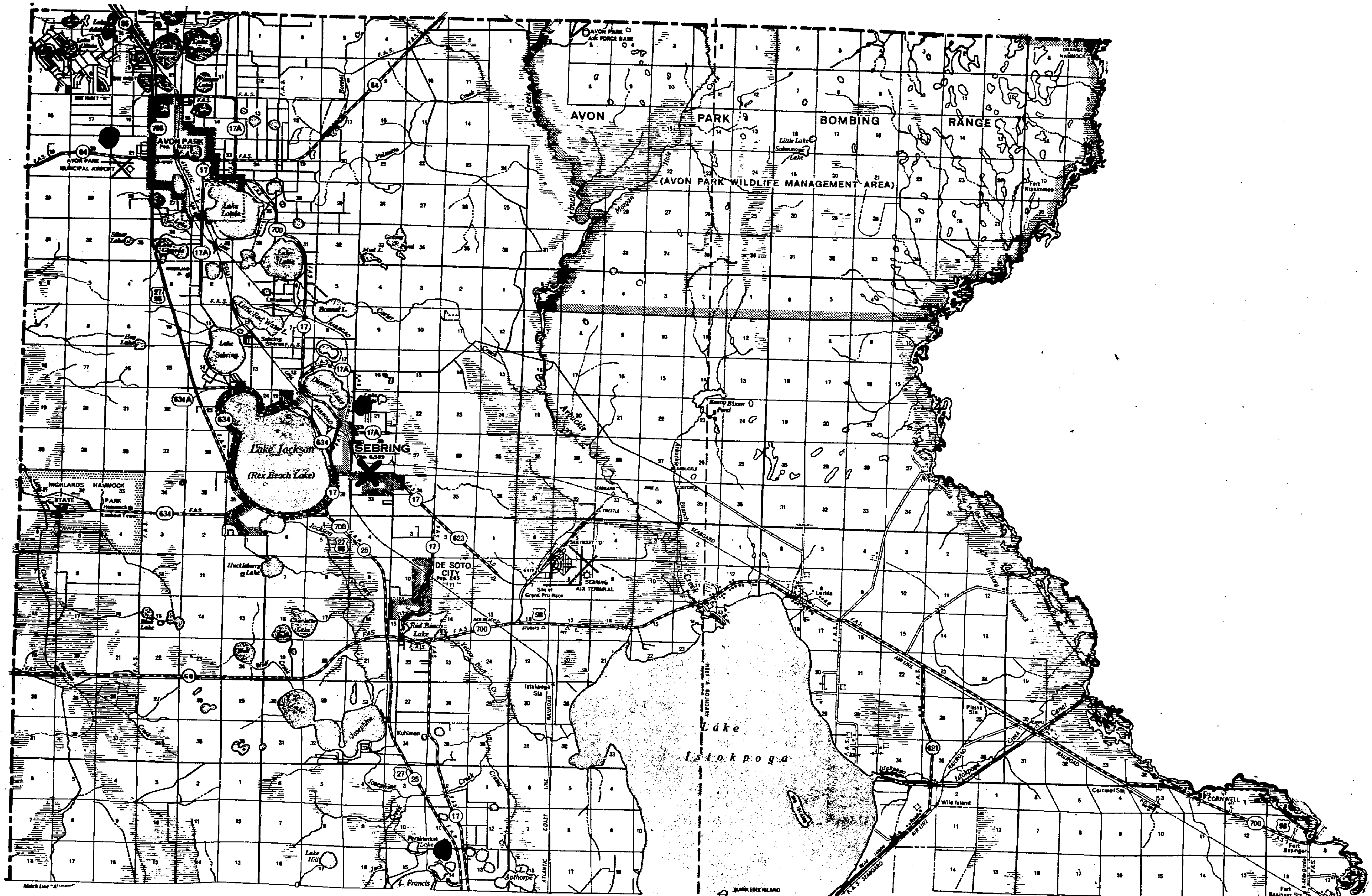
"foreigners" and are insulted. This has not been tested with enough people to determine its validity, but will be further explored.

Education programs are now being used by the nurse in conjunction with clinics, but will be stepped up next year. A slide series is being developed depicting child care, prenatal care, nutrition, etc., which will be appropriate for use with the migrant groups. Demonstrations and displays will be used. Methods of presenting information will be reviewed and refined.

One barrier to the overall health education effort is language. In an attempt to overcome this, the health educator is taking a Spanish course.

It is premature to discuss effectiveness of the educational effort, as it has been confined to information gathering, becoming acquainted with the community, and with limited consultative services. However, it can be assured that the preliminary steps now being taken will contribute to the success side of the scale in programs planned for the coming year. Also, it is obvious that time allotted to Glades-Hendry is not adequate to do the best possible work.

In summary, the health education phase of the migrant health program is in its infancy in Glades-Hendry Counties, and does not lend itself to meaningful appraisal at this time. However, all indications point to its effective incorporation into the Project.



HIGHLANDS COUNTY

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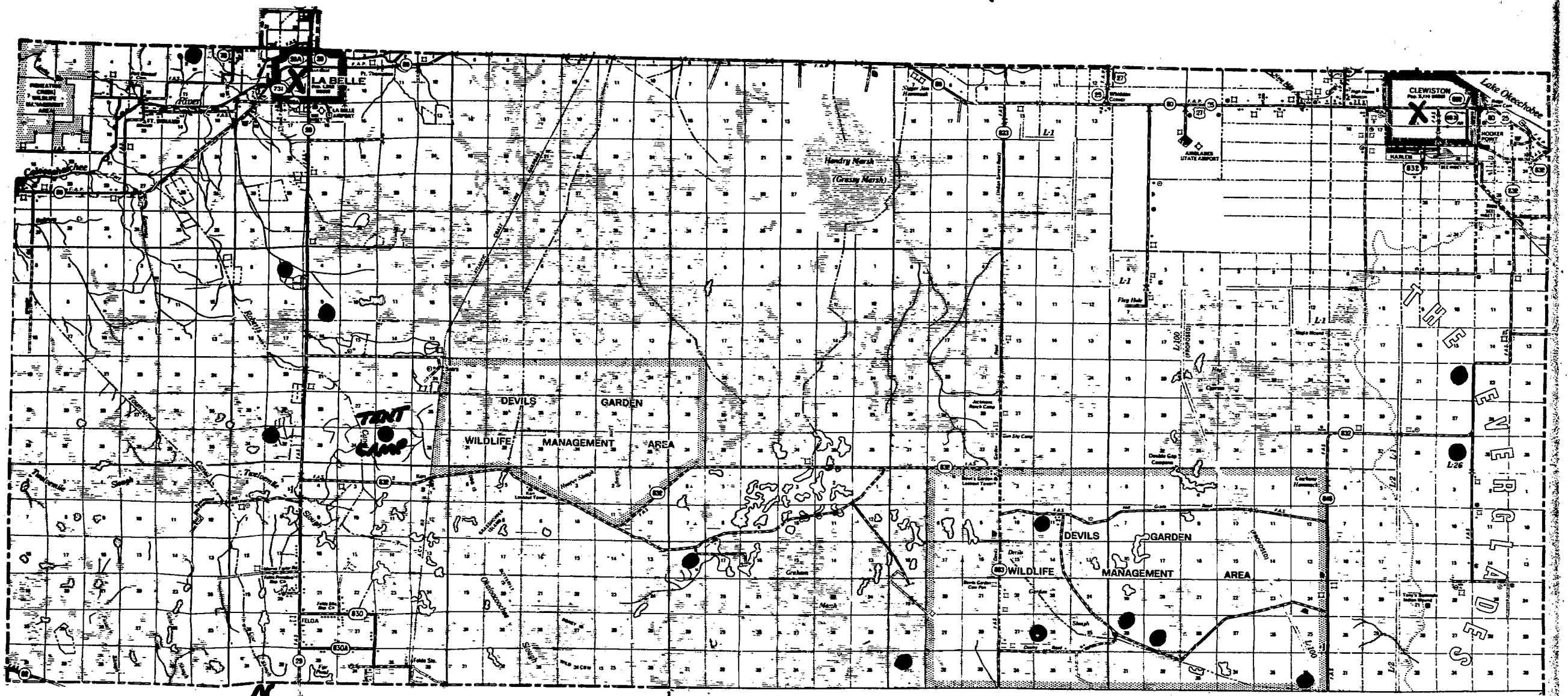
● DENOTES CAMPS

X DENOTES CLINICS

4 MILES



HENDRY COUNTY

● DENOTES CAMPS

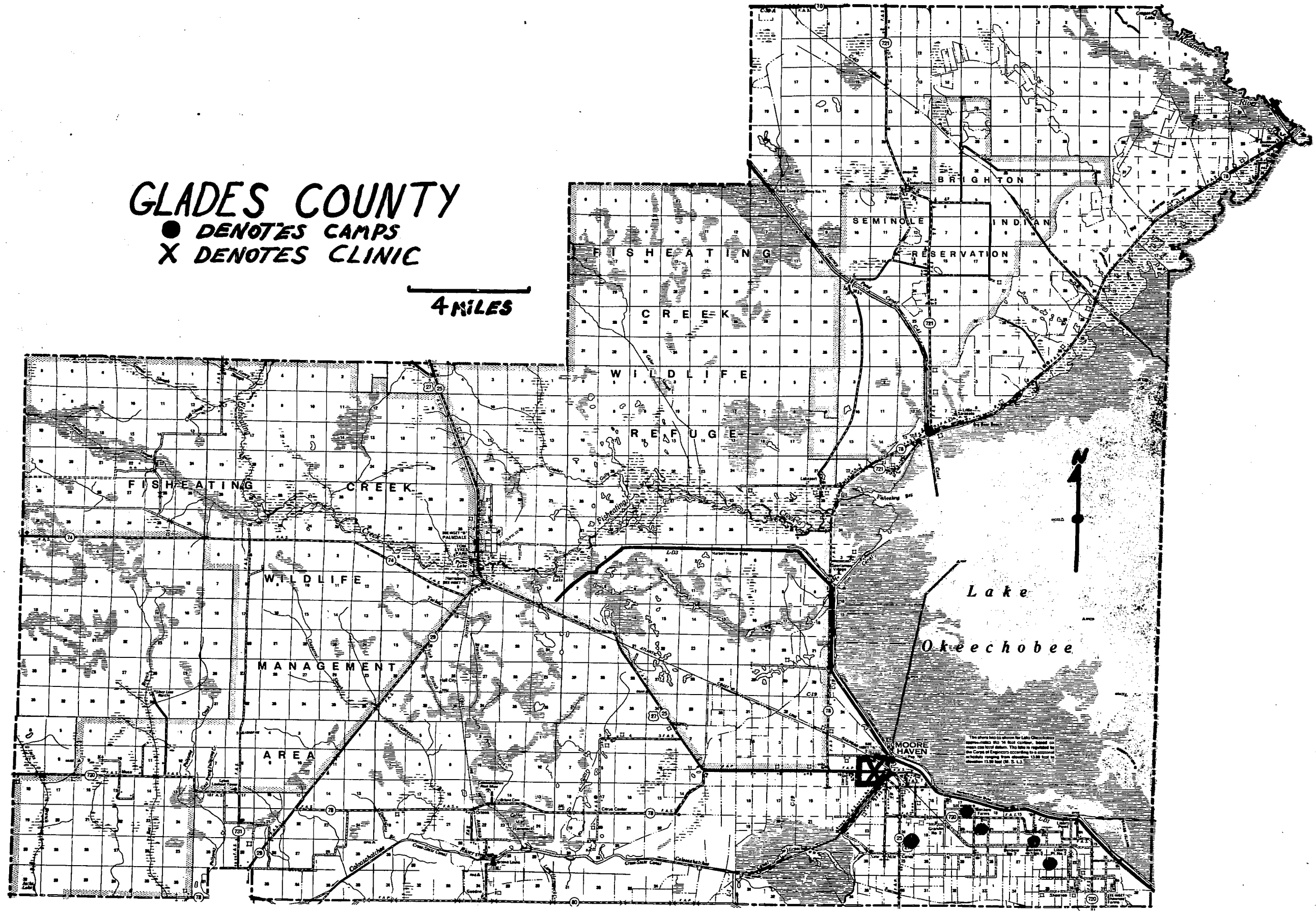
X DENOTES CLINICS

GLADES COUNTY

● DENOTES CAMPS

X DENOTES CLINIC

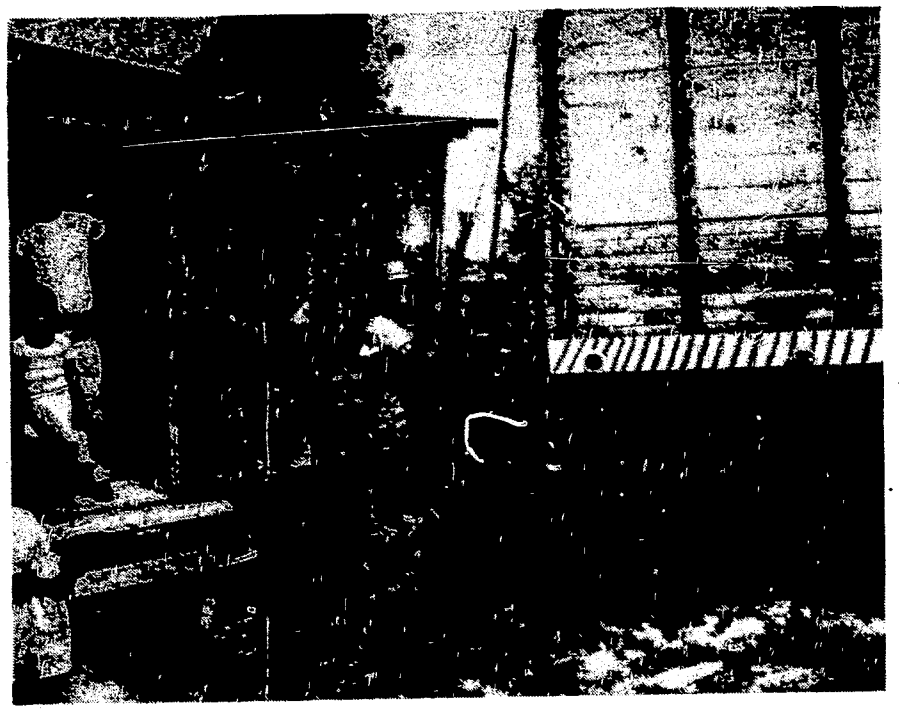
4 MILES

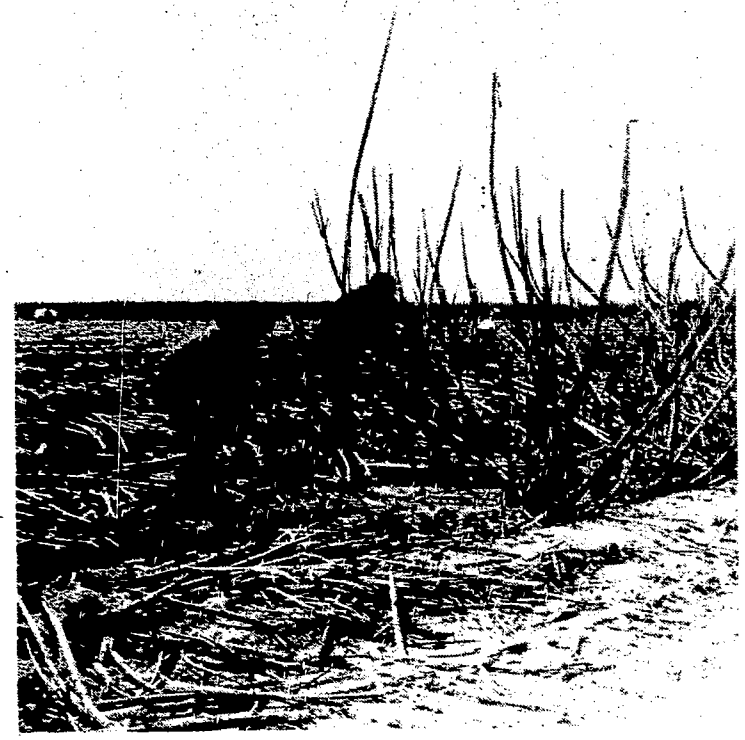


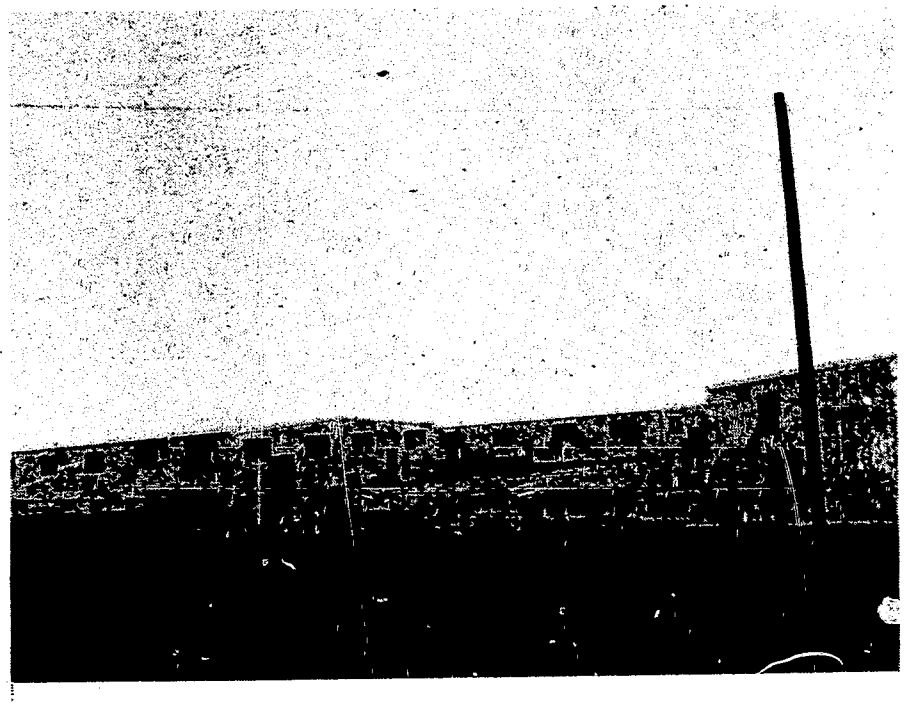
UPPER LEFT: "Open Air" Clinic at the Tent Camp in Hendry County. The clerk and nurse are often assisted by children volunteers, many of whom should be in school.

UPPER RIGHT: Health Officer examines Marguerita who has had a congenital defect of the left arm since infancy. Note the interior of the Clinic Room which the grower provides for health department use.

LOWER LEFT: All the "comforts of home" consist of little for some migrant children. Hopefully this youngster's children may have a brighter future.







UPPER LEFT: Migrant worker loads TV antenna on truck as family prepares to leave Glades County for work "upstream." Workers have no choice but to be "rolling stones."

UPPER RIGHT: Cane cutters using razor sharp machetes move down a row of cane in a burned-off field. The work is dangerous and dirty. Few domestic migrants will do it.

LOWER LEFT: An offshore labor camp operated by a sugar company in Glades County. These camps are superior to many provided for domestic migrants. Sanitarians have little trouble with them.

LEE COUNTY HEALTH DEPARTMENT

Joseph W. Lawrence, M.D., Director

Area of County: 786 sq. mi.

Resident Population: 70,000

Number of Migrants: 4,000

Migrant Project Staff: 1 Public Health Nurse
1 Sanitarian
1 Health Educator (part-time)

Period covered in this Report: September 1, 1964 - May 31, 1965

LEE COUNTY

This report covers primarily Project activities from October 1, 1964 to May 31, 1965. Little was accomplished during September, as no personnel were employed until the first of October when the Project sanitarian began his dutues. Difficulty was experienced in filling the nursing position, but a public health nurse was finally employed during the middle of February.

Migrants live and work in Lee County for about eight months of the year. In a way, the county could be considered a labor pool, due to the fact that growers in neighboring counties draw on our migrant labor supply. Lee County raises and harvests vegetables, citrus, and flowers. The gladioli industry is one of the county's most important economic assets.

The State Employment Service estimates that there are 2,500 migrants in Lee County. Our survey (contained in the Sanitation Section) of part of the county indicated more than this number.

Regardless of any official definition of a migrant, we have many in our community in which the bread winner migrates along the stream during the year, but his family remains in Lee County throughout the entire year. Thus, he is truly a migrant and his family would be listed only technically as migrants. Nonetheless, for all practical purposes, they would have to be included as migrants. This tends to distort the figures of the estimation of migrants in Lee County, since the listing of migrants in the State Employment Service and the U. S. Department of Agriculture cannot accurately list the migrants and all of their dependents. It is our feeling that there are at least half again as many migrants in Lee County as are estimated by the State Employment Service or approximately 4,000.

The remainder of this Report is divided into two parts, the first is the Sanitation Section, the second is the Nursing and Medical Section.

Sanitation Services

A geographic survey of the entire county was made by the Project Sanitarian to acquaint himself with the county migrant situation. Five (5) principal

areas of migrant housing were found: (1) Harlem Heights area at Iona; (2) Charleston Park area at Alva; (3) Estero area; (4) Teter Road Camp east of Ft. Myers and (5) the Dunbar section of Ft. Myers. The Dunbar area is in a low income section of the city of Ft. Myers.

Camps at Harlem Heights and at Teter Road have at one time been permitted but not yearly. These camps are known as Johnson Camps. The Harlem Heights area also includes migrant housing owned by the Graham Estate and a camp newly permitted this year owned by A&W Glad Farms.

Two camps in the Estero area were permitted after considerable work was done with them.

The Charleston Park area was not permitted, but will be in the year beginning July 1, 1965. Probably two camps will be permitted.

The Dunbar area has been completely surveyed by house-to-house visits, as this seemed the only practical way to ascertain the number of migrants, the condition of the housing, and the ownership of the housing.

Conditions corrected as a result of contacts made are:

1. Three privy type toilets which had tilted out of line were completely rebuilt at the Johnson Camp at Harlem Heights. A bad septic tank condition at housing on the Graham Estate property was corrected by laying new pipe and repairing the tank cover. A partially burned building was torn down and rubbish removed.

2. The Thomas Camp, southwest of Estero, has new wash bowls installed, and inoperative draining of the floor corrected in the wash room; grounds which were covered with rubbish are now clean and well maintained. Garbage is properly contained in covered cans and is removed frequently. Their other camp which was constructed last winter has been improved by proper grounds clean-up, wash room maintenance, and better garbage disposal.

3. The Teter Road Camp has been cleaned up and racks have been installed to hold garbage cans; also, the sewer line was repaired.

4. The old Dozier Camp at Charleston Park has been sold and the new owner is completely renovating it under health department

supervision.

5. A location at 2275 Highland Avenue, in the Dunbar area, housing many Puerto Ricans, has been worked on inside and out and the grounds have been considerably improved.

The camp owners of permitted camps have been very cooperative and in these camps, the cooperation of the migrants has been good because a contractor has been in immediate charge of the camp. In the other areas, cooperation has been from fair to poor, both by owners and migrants. This seems to be true, because the owner has a representative in charge of his property who is much more difficult to deal with and the migrants have no one to act as leader for them. Time was not available to truly contact the owners of these properties and thoroughly explain the migrant sanitation program.

The principal problem in getting conditions corrected and then maintaining good housing seems to be basically education of both the operator and the migrants. This takes patience and understanding, particularly with the migrant. Experience indicates that unless the migrant thinks that the sanitarian is sympathetic to his problems, he will continue to be difficult to work with.

As the sanitation portion of the Migrant Program in Lee County is only eight months old, most of the work has only been started. We feel that this program is greatly needed here. Most of the housing is very sub-standard with a range from very poor to fair, in most cases, except for our permitted camps.

The State Hotel and Restaurant Commission cooperated fully with us on two rooming house situations by condemning both of them as presently unfit for operation.

There have been 1,607 visits made to private premises this Project year in relation to migrant activities. The majority of these visits were made during the course of the migrant housing survey conducted in the low-income area of Ft. Myers. Other health department sanitarians assisted in making the survey. This survey will be useful in the future to measure the success

of our environmental sanitation program, especially where it concerns migrants. These visits involved checking on garbage disposal, sewage disposal, water supply, condition of the dwelling and premises, occupation of the occupant (was he a migrant?), number of occupants, etc.

Visits were also made to food handling establishments patronized by migrants. These include restaurants, cafes, bars, and grocery stores. One school with a high enrollment of migrant children was visited.

Nursing and Medical Services

We have one public health nurse who is under a different migrant health project and spends at least 80 per cent of her time working strictly with migrants. We have another public health nurse who was hired under this present Project and spends 100 per cent of her time working with migrants. The latter nurse began work on February 15, 1965. Time spent by the clerks on work involving migrants is estimated at approximately 25 per cent.

The number of migrants given free examinations by Dr. Bartleson, a private physician, at his once-a-week voluntary clinic at Harlem Heights, from October 1, 1964 through May 31, 1965, was 466 patients. A public health nurse assisted the physician at these clinics.

Approximately 3 per cent of the Puerto Rican migrants fly to Puerto Rico for the delivery of their children.

There were eleven emergency dental visits to a private dentist for a total of $72.50.

Our migrant records show:

1. 1,198 immunizations
2. 4 Tuberculosis patients
3. 116 parasite treatments
4. 291 maternity, field and office visits
5. 148 infant and child health visits
6. 22 school visits in the interest of migrant health
7. 30 eye examinations
8. 4 eye referrals with glasses donated by the Ft. Myers Lion's Club

9. 26 children weighed and measured.

There were very few known venereal diseases among the Spanish migrant population. We are unable to determine the number among the Negroes.

We have no known diabetic cases at this time.

We have had four Florida Crippled Children referrals, and one Council for the Blind resulting in two migrant children having heart surgery and one child having an operation for congenital cataracts.

We have been able to help correct some of the health problems by the convenience of our outlying clinics, including some night clinics to reach the parent that is working.

The use of our referral agencies, such as Florida Crippled Children's, Council for the Blind, and other charitable organizations, have greatly contributed to this also.

Some of the pressing problems that still remain are: (1) lack of funds for hospitalization; (2) inability to find physicians willing to staff night migrant clinics; and (3) lack of day care centers.

If some form of group hospitalization could be made available to the migrants, it would be of great benefit.

They also have a great need for dental care. At the present time, we are limited to emergency care, but their teeth need preventive maintenance badly. Many have never had a filling and their cavities are so large that the only recourse is extraction. This leads to poor nutrition, due to inability to eat the proper diet. There is need for education in this field. It is sad to see so many young people with front teeth missing and no money for replacement. This could cause an emotional problem, also.

Education in sanitary procedure is needed due to the many cases of diarrhea and intestinal parasite infestation. They need to learn the value of cleanliness for good health and also for acceptance into the community.

There has been much progress made since the start of the Migrant Project. The children are attending school more regularly and the parents are showing more interest and making more of an effort to accomplish this.

The need for day care centers cannot be emphasized too strongly as some school age children are still being kept at home to care for very young infants and preschool children. Besides the school problem, the younger children are receiving very inadequate care, improper supervision, and are being subjected to hazardous conditions in the homes.

The migrants accept the facilities of the health department more readily now as shown by our statistics and their cooperation is very good. They are coming to maternity clinics earlier and this enables us to give them better prenatal care. Our postpartum clinics are growing, also. We feel these successes are due to health education.

They accept child spacing services eagerly. We have 66 patients on the birth control pills plus numerous others on our other contraceptives.

We feel the Migrant Project has proved its worth in helping these people adjust to many of their problems. There are many more to be solved. One of the most rewarding factors has been the confidence the people have gained in the health department and their willingness to use all of its facilities for both large and small problems. The trust of the Spanish migrants was gained largely by the nurses' willingness to attend Spanish classes in order to communicate with them more adequately.

A further break-down in the nursing report on the volunteer clinic indicates that Dr. Bartleson held 34 migrant clinics from October 1, 1964 through May 31, 1965, which were half-day clinics. As noted, he saw 466 patients which are broken down into age and sex groups in the following manner: 104 school children; 192 preschool children; 131 adult women; and 39 adult males.

Dr. Bartleson has refused to accept any compensation for these clinics

but at $25 per clinic, this would amount to $850. He has referred quite a number of patients to other doctors in the county for more extensive care than he could render and the value of this would be rather difficult to estimate, as the doctors also donated their services.

Weekly night clinics were held for the migrants in the Harlem area by the migrant nurse. We were unable to institute our medical night clinics due to the inability to get physicians to mann these clinics, even at a gratuity of $25 per night clinic. We sincerely hope to overcome this difficulty in the coming year by hiring a part-time physician who would man the evening clinics and work on a twenty-hour week basis.

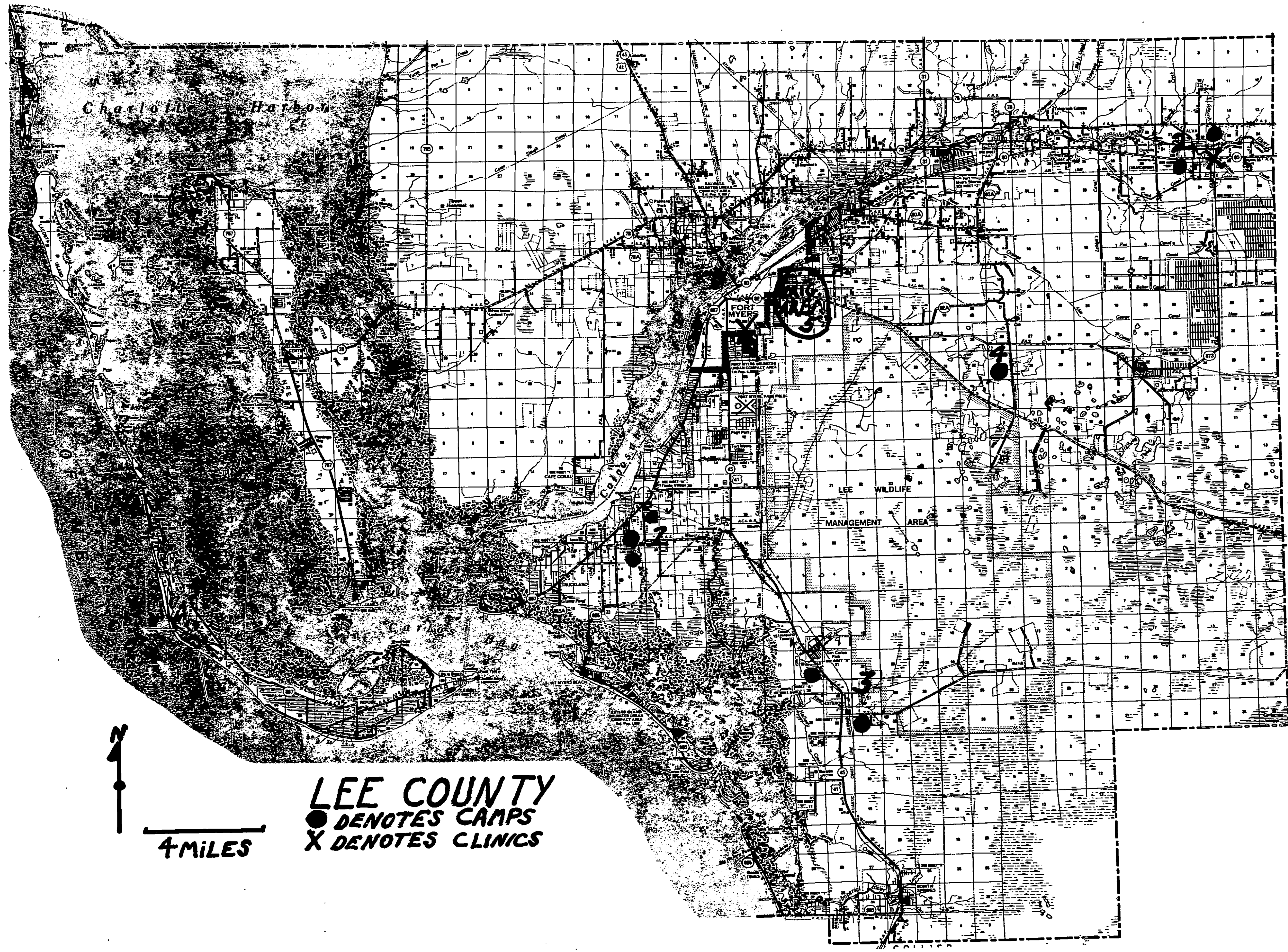
Considerable services are rendered to the migrants other than those furnished through migrant funds. An attempt was made by the Lee County hospitals to break down the admissions for the migrants, both the emergency room and for in-patient hospital care. During 1964, the two hospitals in Lee County saw in the emergency room approximately 800 migrant patients and the value of this service would be roughly $4,000. Those admitted to hospital in-service care numbered approximately 268 patients and the estimated value of this service, using the State Hospital Service for the Indigent Per Diem Program, would be roughly $4,020. This indicates that there is a great need for some type of hospitalization program to be instituted by the Federal Government under this Migrant Health Project. These people are very necessary to our economy and their health is important to all of us. If a physician were hired, even on a half-day basis, the cost of the emergency room care for migrant patients in the hospital would be practically eliminated.

There is a real need for the continuation and expansion of the Project as we have been slow in getting it started and are barely scratching the surface in the furnishing of proper sanitation, nursing, dental and medical care to these migrants.

We hope to extend the program this next year to render more complete services to our migrant population who stay with us approximately eight months of

the year.

If the program is continued and expanded as hoped, we believe that we could give the migrants in Lee County equally as good care as other residents in the county are able to obtain and, furthermore, we believe that they have a right to this care.


Charlotte Harbor
FORT MYERS
LEE WILDLIFE MANAGEMENT AREA
N
4 MILES
LEE COUNTY
● DENOTES CAMPS
X DENOTES CLINICS

This private physician volunteers his services one-half day per week, saw over 800 migrant patients last year. Clinic is located at Good Shepard Mission.

Lee County supplies much of the nation's gladioli. Migrants work with resident labor in the fields.

Outdoor toilets in labor camps save operators plumbing bills but often create sanitary nuisances.

Well baby clinic is one of a variety of clinics scheduled by the Lee County Health Department Director.

MANATEE COUNTY HEALTH DEPARTMENT

George M. Dame, M.D., Director

Area of County: 701 sq. mi.

Resident Population: 77,000

Number of Migrants: 5,000

Project Staff: 1 Public Health Nurse
1 Sanitarian

MANATEE COUNTY

The Migrant Project in Manatee County officially began on May 1, 1965. These personnel are still undergoing orientation and training and have just begun to provide services to migrants, therefore a progress report is not submitted at this time.

Plans for the Forthcoming Year

The Community Services Foundation has opened a Vista Training Camp near Piney Point in Manatee County. At the present time, there are about 50 trainees living at the camp. Another project relating to migrants is the large Multi-service Day Care Center to be opened in Palmetto by Suncoast Progress, Incorporated. Suncoast Progress is a private corporation administered by a board of directors operating under the Economic Opportunities Act. The director of the Manatee County Health Department is a member of the Board of Directors of Suncoast Progress which meets once a month in St. Petersburg. Approximately half of the families who will be served by the Day Care Center are migratory agricultural workers, some of whom use Manatee County as a home base. It is proposed that the Center will hire two nurses and these nurses will be trained by the county health department and will continue to be assigned to the health department for supervision, although they will be paid by Suncoast Progress. Public Health Nurses of the health department will, at times, hold certain clinics in the Day Care Center. The Public Health Nurses and Sanitarians will also visit in the homes of families served by the Center in order to provide home nursing care and consultatory services in home making and environmental health.

The county health department is developing a project for a Mobile Health Clinic to serve rural areas and migrants. We expect to coordinate the Mobile Clinic Program with the Day Care Center Program. One of the most significant health problems in the migrant group is that these people have no family physicians and actually lack access to physicians; therefore, they wait until illness progresses to a critical stage before seeking help and go to the emergency room, where a very high per cent require admission. The county health

department wishes to develop a program of Migrant Health Evaluation and Referral to doctors' offices in order to alleviate the aforementioned problem. It is intended that the Migrant Project nurse will devote a major part of her time to working with this problem. A principal function of the Mobile Clinic also will deal with this matter and will naturally involve the other public health nurses. Migrant workers and their families are regularly seen in the various health department clinics. Exactly 8 per cent of the women who had babies through the indigent Maternity Clinic last year were classified as migrants. This statistic is very reliable, as all of the indigent Maternity Clinic cases are investigated by the County Welfare Department which prepares a written report. The percentage would be higher if we included several Spanish-American women of migratory background who have apparently become residents, as they have lived in the county continuously for more than one year. The percentage would be even higher if we used the total number of cases served in the Maternity Clinic, rather than the number who actually delivered babies - as many of them, say about 10 or 12 - moved elsewhere before reaching term. Two hundred and forty-three women were attended last calendar year and 183 delivered babies. About twenty per cent of the cases seen in Venereal Disease Clinics were migrants. In the Tuberculosis Clinics, some 12 per cent were migrant agricultural workers, this includes a total of 200 people. Twelve per cent of the 3447 children seen in the Well Child Clinics were migrants. The numbers of migrants seen in these clinics will probably continue to increase as the agriculture industry grows.

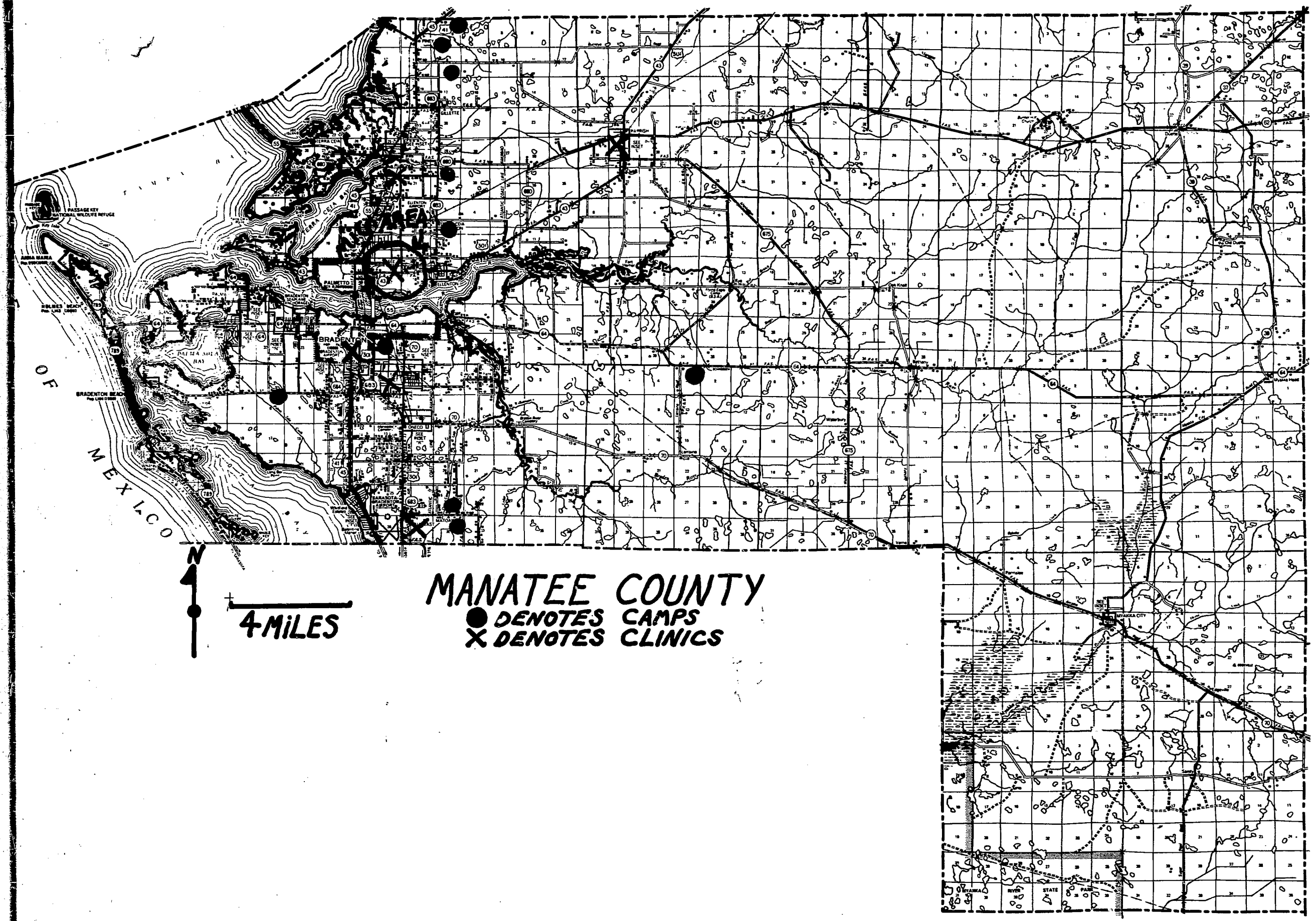
Since last year, three new camps have been approved, bringing the current total to ten with accommodations for some 500 persons. The health department has, for many years, inspected and licensed the migrants' camps and during these years, many have come into being, lasted for a time, then passed out of existence for one reason or another. Some of these old camps which are no longer licensed are still standing, and it is necessary that we inspect them from time to time to make sure that they are not being used. Occasionally, we find they are, and we must either make them improve the camp so that it can be approved and licensed, or make them stop using it.

The new Migrant Project sanitarian will now take over the pricipal role in the Migrant Housing Program and will work with the substandard housing inspector who is employed by the County Building Department. The sanitarian previously responsible for inspecting migrant camps will, of course, continue to work with him as will most all of the other sanitarians. The Project sanitarian will, of course, utilize every means to improve environmental health conditions for migrants. Undoubtedly, the greatest migrant health problem in this area is the need for better housing, and working to improve housing, may demand the greatest part of the sanitarian's time.

Our mental health worker states that he rarely sees migrants, no more than one or two a year. Whether this is due to lack of problems or lack of referrals is not at this time known. An effort will be made to evaluate migrant mental health and offer services if needed.

The dental clinic contains perhaps 5 per cent migrants, most of them children referred from the Well Child Clinics and women referred from the Maternity Clinic. It is possible that this per cent can be increased by holding a dental clinic in the field. The county health department health educator position is currently unfilled for want of finding a qualified person to fill it, but in the past, has provided a great deal of help to migrants.

The director will continue to provide clinic services and to develop programs to improve migrant health.


PASSAGE KEY NATIONAL WILDLIFE REFUGE
ANNA MARIA
HOLMES BEACH
BRADENTON BEACH
PALMA SOLA BAY
TERRA CEIA BAY
BRADENTON
PALMETTO
ELLENTON
GALLETTE
SEE INSET
OF MEXICO
N
4 MILES
MANATEE COUNTY
● DENOTES CAMPS
X DENOTES CLINICS
MYAKKA CITY
MYAKKA RIVER STATE PARK

ORANGE COUNTY HEALTH DEPARTMENT

Wilfred N. Sisk, M.D., Director

Area of County: 916 sq. mi.

Resident Population: 297,000

Number of Migrants: 10,000

Migrant Project Staff: 2 Public Health Nurses
2 Sanitarians
1 Clinic Physician
1 Clinic-Aide

Period Covered in this Report: September 1, 1964 - May 31, 1965

ORANGE COUNTY

There are more than 3,000 migrant farm workers in this county at the peak of the season. With their dependents, they make up a segment of our population that comprises between 7,000 and 10,000 people. This number is here approximately six months of the year, although this population is quite mobile and the group may not always be made up of the same individuals throughout the full season. A smaller number remain through the spring vegetable and orange season so that there are an appreciable number of migrant families who remain in this county for as much as nine months. There are a small number of migratory workers who come in and out of the county even during the summer months, but this group is hardly large enough to warrant the operation of a full schedule of treatment clinics. We may later want to suggest an abbreviated summer schedule.

While the date of arrival is very irregular and there is much moving in and out at all times of the year, the largest group of people being to arrive in the latter part of September and the number reaches a peak by the first of November and remains at this level until well into March. There is some orange picking and some vegetable work on into the month of June. Almost all who are going to travel will have left the county by the first of July.

These people live in all parts of the county, although there are some specific labor camps in the western part of the county. Most migrant farm workers who come to this area are Negroes, although we do have a few Mexican workers and a very few Cubans. A sizable number of them live in Orlando, but we consider Eatonville, Apopka, Zellwood, and Winter Garden the chief areas of concentration. There are also some houses and camps in the rural areas near these small towns. All of these small towns except Eatonville are in the western part of Orange County.

I do not know of any adequate way to determine the number of farm workers who consider this local area "home", but who migrate during the summertime to seek farm work elsewhere. There is without question a large number of people

in this category. I would say that there are a minimum of 10,000 in this group. These people, provided they have lived in Orange County at any time for twelve consecutive months (and most of them have), receive medical treatment and hospitalization in the regular course of the county programs. The county maintains a treatment clinic with three full-time physicians and approximately 30 internes and residents to serve these clinics. The county spends approximately $325,000 a year for indigent hospitalization and the above group of people receive their proportionate share.

We have, in Orange County, twelve labor camps, but usually only nine or ten operate each season. These camps are almost exclusively for single, male workers. Most of our other migrant laborers have some family and find housing scattered throughout the county as indicated above. With the restrictions on the employment of foreign workers, it is quite probable that even fewer than ten camps will be operated this next year. The capacity of the licensed camps in the county is 1692.

Some delay was encountered in getting approval for the personnel involved in this Project, and we did not fill all the positions until February. The normal coding procedure does not lend itself to the separation of services provided for various groups of people. For this reason, the amount of work indicated on any tabulations sent to the State Board of Health does not reflect the entire volume of work done in this area. We believe that we have this administrative procedure solved in a satisfactory manner so that beginning the first of July it will more nearly reflect the actual services furnished migrant families.

Family and Nursing Health Service

An excess of 170 nursing and home visits were accomplished in the short period of our Project activity. Two Public Health Nurses have specific responsibilities for these health services. A part-time physician conducts the medical clinics which includes diagnosis and treatment. The nurses assist in this endeavor and perform all follow-up visits and evaluate medical progress

and family conditions. These nurses also make arrangements for welfare recipients to receive additional services. They also follow through for dental services, immunizations, etc. Eight hundred and seventy-one immunizations were given this season.

To provide suitable services of this nature, the Orange County Health Department provides, in addition to salary and travel of personnel, a $5,000 X-ray machine; Xerox copying machine for duplicating records; additional desk space; office supplies; clerical service and clinic aide services; dental services and supplies from two staff dentists.

Our clinics up to now have been relatively small, but any clinic which is busy will require at least two staff nurses, a clinic aide, and two clerks. Contact has been made with the local Council of Churches, who state that they may be able to offer us some voluntary clinic assistance in these clinics. During the height of the season, when we will have virtually continuous clinics, it is obvious that our two Project nurses will have relatively little time to make home visits. We have a very thin nursing staff and, even though the county will be furnishing us several new nurses this coming year, we may find it impossible to make as many home visits as would be desirable for migrant families.

Sanitation Services Related to Migrant Housing and Work Location

Two full-time professional sanitarians are assigned to this Project area. All factors pertaining to the migrants' environmental health conditions are considered and investigated. Specific subjects include eating establishments; housing facilities; water supply, sewerage disposal; garbage disposal; laundry facilities; insect control; rodent control; grocery stores and meat markets; and adequate drainage. Rules, regulations and laws, as provided by the State of Florida regarding migrant camps, are adhered to. Defects found are analyzed and corrections obtained. Sanitarians made 60 visits to migrant camps to check water supplies, sanitary nuisance complaints, etc. since the first of the year. In addition to the above areas, the Orange County Health Department has assigned the services of a Sanitary Engineer as needed or indicated.

Health Education Services

At the present time, health education activities consisting of: immunization needs, planned parenthood, nutrition; communicable disease control and other preventive health hazard measures depend upon the public health nurses and professional sanitarians. However, a health educator has joined the staff of the health department and his services will now be utilized as a resource person in developing health education materials to assist our other professional staff in carrying out an even more effective and efficient Project program. The addition of this staff member will also give us the opportunity to extend our services into programs for growers.

Project Objectives

Our objective for the first portion of 1965 was to increase the nursing and immunization services available to migrant workers and to increase the sanitation services available to these people. Our two nurses and two sanitarians have worked in the area where migrant farm workers find housing and we have made improvements both in the services and in the sanitation of the area involved. Because our Project was late in getting started, we did not accomplish as much as we would have desired. Without the supplemental financial support requested and now approved, we were limited in the medical treatment facilities which we could offer. We have enlarged the physical facilities available to both clinics in Winter Garden and Apopka so that we will have room for medical treatment clinics in these areas. We are greatly expanding our family planning services, utilizing both the contraceptive pills and the interuterine devices. We started some small treatment clinics late in the season, but we were unable to get this started in time to serve the biggest group of migrant farm workers.

Plans for the Coming Season

We are fortunate in having a retired physician in the county who is vigorous and active and who desires work part of the year but is not interested in full-time, year-around work. We plan to use him to operate the clinics for

medical treatment and will pay him on a per clinic or per day basis. We will begin clinics in the early fall and will increase the number as the migrants come into the county, until we are furnishing the equivalent of the full-time services of a physician.

ORANGE COUNTY

Apopka and Winter Garden
Migrant Health Clinics

From March 1, 1965 - June 1, 1965

CLINIC SESSIONS: 53 four-hour Sessions - Generalized

1 Physician in Attendance; 3 PHN's and 1 Clerk

I. TOTAL ATTENDANCE: 221 RETURN VISITS: 165

II. ETHNIC GROUPS:

a. Mexican	15	c. Puerto Rican	1
b. Negro	117	d. White	87

III. SEX: 48 Males 173 Females

IV. AGE GROUP:

a. 0-1	30	d. 15-45	158
b. 1-4	16	e. 45 plus	9
c. 5-15	14		

V. SERVICES GIVEN:

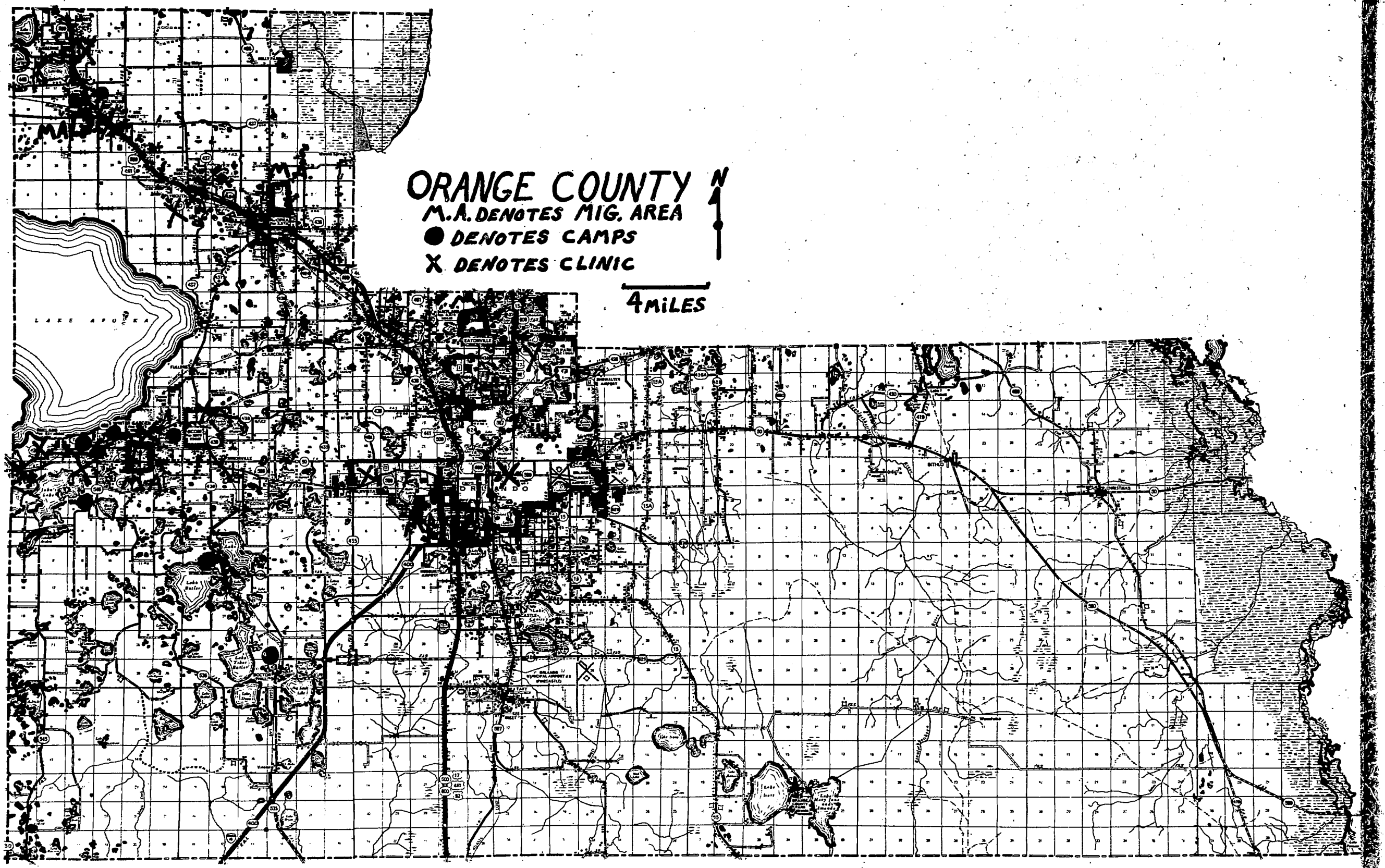
a. Exam. by physician	192	c. Medication and/or Treatment	62
b. Seen by nurse	221		

VI. REFERRALS: Florida Crippled Children's Commission 3

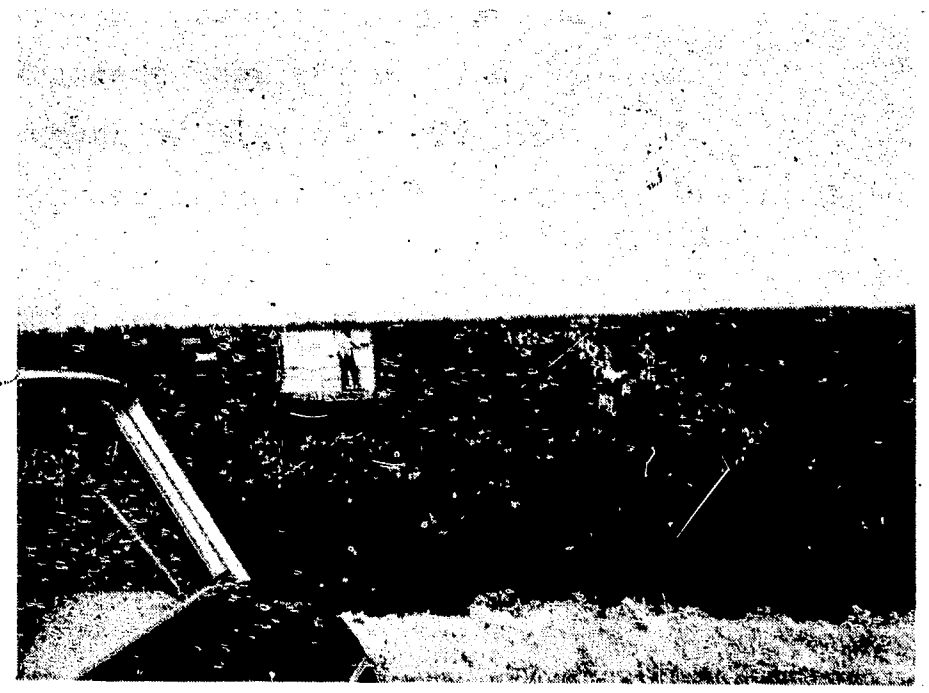
VII. PHYSICIAN'S DIAGNOSIS

a. Ascites	2	m. V.D.	3
b. Cardio Vascular	6	n. E.E.N.T.	2
c. Communicable Disease	2	o. Larva Migrans	0
d. Child Health Supervision	48	p. Toothache	0
e. G.U.	2	q. Anxiety Syndrome	2
f. G.I.	0	r. Mental Illness	11
g. Intestinal Parasites	1	s. Nutritional Diseases	3
h. OB-GYN - Family Planning	136	t. Hernia	0
i. URI	2	u. T.B.C.	2
j. Skin Conditions	7	v. Epilepsy	2
k. Minor Injuries	7	w. Staph Infections	5
l. Asthma	0	x. Ulcerated Limbs with secondary Infect.	8

REFERRAL TO LOCAL HOSPITAL: 1


ORANGE COUNTY
M.A. DENOTES MIG. AREA
● DENOTES CAMPS
X DENOTES CLINIC
4 MILES
N
LAKE APOPKA

Worker picks oranges in Orange County grove. Many citrus workers are offshore labor from the British West Indies. Surveys indicate U.R.I. top list of ailments of citrus workers.



Vegetable fields in muckland area of Orange County stretch for miles. Field sanitation is a big problem for sanitarians in all migrant counties.

POLK COUNTY HEALTH DEPARTMENT

James F. Cason, M.D., Director

Area of County: 1,861 sq. mi.

Resident Population: 212,000

Number of Migrants: 22,000

Migrant Project Staff: 1 Public Health Nurse
1 Sanitarian

Period covered in this Report: September 1, 1964 - May 31, 1965

POLK COUNTY

Introduction

In 1956 the United States Department of Agriculture figures showed that Polk County produced one-sixth of all citrus produced in the United States and a very considerable percentage of the World's output. Since these figures were printed, Polk has lessened its leadership due to increased planting in Florida and foreign counties. Still, we have an agricultural crop that is harvested by migrant workers. This means we have a human problem.

In the past, the Polk County Health Department has ministered to all indigents with little consideration whether they were migrants or not. Something was needed to make us realize that here is a problem involving a large number of unfortunate people.

In a recent issue of the Saturday Review, the dilemna of the migrant family and particularly the children was discussed with passion and understanding. Unfortunately, solutions to this dilemna were vague as presented.

We hope the Federal Migrant Program will give us a more clear focus in working with this group to help alleviate their suffering. Eventually, this dilemna will be solved.

Nursing Services

Polk County once more has seen the November to May influx of migrant workers come and go and the health department has experienced its first six months of operation in the accelerated program for migrants made possible by Migrant Project funds. The total migrant population has not differed noticeably from other years nor have the problems, although some were compounded by the in-migration of white labor who had been given unrealistic information about work opportunities, wages, etc. in this area.

The goal of the Project, to offer more comprehensive services to a greater number of migrants was reached. However, the ideal of meeting minimum needs of all migrants was not even approached. This failure is

believed to be due to many complex factors only a few of which are resolvable by a local health department.

Actual implementation of the Migrant Project (in this county) was delayed until December 1964 for the following reasons. Our agency policy of employing no staff personnel to perform specialized functions necessitated our waiting for assurance that we could account for the time of our nursing allocation on an equivalency basis. We were not immediately able to employ a qualified nurse and when found, it was necessary that she receive the usual month of orientation required of all staff.

In spite of these delays the aim was reached by the following methods:

1. The total nursing staff of 42 nurses located in all nine area offices of the department were made more keenly aware of migrant problems. This was done by use of appropriate literature, films, data presentation, and small group discussions.

2. High priority for nursing time was assigned to seeking out migrants, explaining the services available, and assisting them in making use of all resources.

3. Migrants were identified as such and the program explained to other agencies, civic clubs, volunteer health agencies, etc. when their assistance was sought in making plans for individual migrant care.

4. Several clinics were held weekly in all nine district offices of the health department. A series of four evening clinics was held in each of two areas where immunization levels were low.

5. The policy of adhering to strictly preventive work in all clinics was relaxed and treatment not requiring extensive laboratory work was given.

The following table gives numbers of migrants as compared to other patients served in selected basic public health programs from January 1 to

May 31, 1965.

(To be counted as a migrant for tabulating purposes, required that the nurse giving the service remember to place an "M" by the code figure of each migrant as she recorded her days work. Therefore, it may be safely assumed that the figures are conservative.)

	MIGRANT	TOTAL	% MIGRANT
Adm. to Communicable Disease Service	4	65	6%
Field Visits	22	81	27%
Treated for parasites	78	488	15%
Number of individuals given at least one complete immunization	1100	4674	12%
Immunization series completed	3998	18,933	21%
Adm. to Venereal Disease Service	15	215	6%
Adm. to Tuberculosis Service	60	1262	4%
Field and office nrsg. visits	197	3536	5%
Cases hospitalized	3	38	7%
Pt's Adm. to Maternity nrsg. visits	133	995	13%
Field and office nrsg. visits	535	4600	11%
Adm. to Child Spacing Program	136	598	22%
Children under 5 given Medical Service	99	808	12%
Children adm. to nrsg. service	353	6556	5%
Field and office nrsg. visits	855	11,590	7%
Adm. to Cancer Service	6	510	1%
Cervical cytology exams	50	478	10%
Adm. to Diabetic Service	5	209	2%
Adm. to Heart Disease	6	198	3%
Adm. to other Chronic Disease	21	483	4%
Adm. to Morbidity Service	136	484	28%

Of the total 17,545 patients served in the above listed selected programs, 2,152 or 12% of the total were migrants. On the basis of nursing visits related to all services of the health department, 10% of the 30,972 were in the interest of migrants. Thus, while allocation from the Migrant Project pays the salary of 1 nurse out of 42, or for 2% of the total nursing time, approximately 10 per cent of the nursing time is used in the migrant's interest.

The following resumes from individual patient records show examples of services offered.

1. An 18 month old white boy from a migrant family was brought to one of our well child clinics. It was obvious that the child was quite ill. Upon examination he was diagnosed as having pneumonia. Because the child was still retaining fluids, out-patient treatment was started. Daily home nursing visits and injections were made for the next five days. During these visits, it was noted that the other four children appeared pale, although their diet as listed by the mother seemed reasonably adequate. After further questioning, the children and parents were checked for parasites. All were treated and furnished with supporting medication.

2. A middle-aged migrant Negro man reported to a Monday morning clinic with a badly lacerated right thumb that had been caught in a motor hoist the Friday before. He said that he had not sought medical attention because he did not think the injury serious. He had recently arrived from West Virginia looking for employment which he had not found. Another migrant living in the same area had offered him a bed and a few dollars for helping him repair an old car. It was on this job that he had hurt his thumb. After examination, our clinic physician thought that amputation might be required, and so the patient was taken to the County Hospital by a public health nurse. The finger was sewed and daily soaks and dressings ordered. Subsequent transportation for trips to the hospital was furnished by the Red Cross.

3. A large non-English speaking Mexican family from Texas was reported to this department by the State Health Officer of South Dakota as being family contacts of an active case of Tuberculosis.

The family was located and brought into the clinic where all received skin tests and X-rays. Six of the ten contacts were found to have very positive reactions to P.P.D. This group was put on anti-Tuberculosis medication. The father of the family speaks English, is of average intelligence and is concerned about his family. Considerable nursing time was used in instructing this man about Tuberculosis and its care. The family plans to leave Florida in the near future and move to Michigan. Arrangements are being made for further follow-up in that state.

4. A young Negro mother and her family move from Georgia to Florida each year. Her husband is an able picker who earns better than average wages during the citrus season and a fair wage at farm work during the spring and summer months in Georgia. This past winter the mother returned to our clinic for maternity care for the third time. Other years she has brought her children regularly for well child examinations and immunizations. She has used conception control materials furnished by our department and thus has spaced her children two years apart. While this family could possibly pay a minimum medical care fee, they are financially eligible for care and the mother has stated that the reason she returns to us is that she has no trouble getting a physician to deliver her in Georgia because we furnish her with adequate records of her prenatal care. It was interesting to learn on her last visit to clinic that she plans to return to Florida the latter part of August and remain until June in order that the oldest child may stay in school the full school year. At the public health nurse's suggestion, the boy was taken to the school and registered last month in order to assure his admittance in the fall.

5. A 22 year old Negro girl was reported to the Venereal Disease investigator as a primary syphilis contact by a private physician.

She was located by the investigator and examined by the physician who found that she had a primary chancre. He also learned that she was allergic to penicillin and without funds for medication. Medication at the cost of $26 was furnished to the girl the same day by the Community Nursing Council through the efforts of a public health nurse who works closely with the Council.

Some patients needed more care than the health department is either staffed or equipped to give. In these instances which came to our attention, the nurse and/or health officer was able to make arrangements for care by a private physician or the county hospital out-patient department at little or no cost to the patient. Frequently transportation could be arranged for through the Red Cross or other volunteers known to the nurses. Medications were often furnished by private physicians who gave us large quantities of professional samples.

The greatest single problem in dealing with this segment of the population is perhaps lack of communication between the individual needing the service and the person or agency prepared to give it. As a group they show little initiative in seeking information about available assistance or in using the information when it is given to them unless a personal and painful emergency exists. The exceptions to this generality appear to be increasing and it is through these persons that the others most often come to our attention.

During the next season we plan to systematically use these people to inform others by encouraging word of mouth notification among them. Also, plans are made to notify by mail and personal contact, work foremen, and town relief personnel of our available expanded services.

Presently allocated funds now make it possible for us to increase the general medical and nursing care we will be able to offer in-migrants during the season to come, as well as to those families left in the communities as the men have moved north during the past month.

Sanitation Services

Months of experience in working with the migrant population among our

regular residents has proven to us that these people definitely do need health supervision and advice from a sanitation standpoint.

We have found it best to minister to these people based on areas of their greatest geographical concentrations. These areas in Polk County are the settlements known as Eloise and the Negro or offshore labor settlements in Haines City known as Oakland, Hill, and areas in and around Ash and Cedar Streets where Latin elements tend to settle. There is also an area known as Lakewood Park, adjacent and east of Davenport, in which a considerable concentration of white migrants congregate in season. Eloise is a large unincorporated area located just outside the south city limits of Winter Haven.

No pure concentrations of migrants only will exist in any geographic area, thus roughly one quarter of the work of a migrant project sanitarian would involve non-migrant service. Conversely, because of scattered settlement, the work of all non-migrant project sanitarians will also include migrant service.

Sanitary Survey: Our experience has shown that in at least 50 per cent of the homes checked in a saturation sanitary survey, a combination of ignorance, apathy and inability or disinclination on the part of migrant homemakers to teach their children correct and proper sanitation has resulted in an "envelope" of substandard sanitation developing around these families.

Thus, even the initial survey of the hundred-plus homes in Eloise has shown a need for corrections and educate-as-you-go procedures -- a slow, but not entirely unrewarding process.

Two prominent factors involving environmental sanitation which have demanded a considerable amount of the sanitarian's time are:

1. Health education directed to landlords to provide decent housing, with proper plumbing and sewage disposal, screening and rodent-proofing.

2. Efforts to eliminate by education or intimidation (when called

for) the migrants habit of piling up garbage in the front or back yards of his dwelling. This habit, added to the apathy of some landlords, has caused many homes to become focal points supplying flies, roaches, rodents, and other vermin not only to the affected premises, but to neighboring areas as well.

Another 50 per cent or less of the migrants surveyed showed an inclination to cleanliness, to bettering their lot and to living decently. These have been encouraged to influence their less enlightened neighbors in a friendly manner. In short, many migrants want to observe sanitation -- too many do not care.

Project Objectives

An idealistic objective would be to reach each migrant family, to instill all conceivable home-sanitation procedures into each family and to establish model migrant communities.

Because we are dealing with the human element, the ideal can only be striven for, never reached, but always reached toward.

Since the Project was activated in this country, we have made progress toward the elimination of basic garbage problems and have eliminated or instituted elimination of over-flowing or defective septic tanks and dry wells, plus open-running effluent from sinks.

Continued vigilance on the garbage and possibly septic tank situations is indicated.

We aim to encourage elimination of privies in general. A dozen of these still exist in the Eloise area. Up to 1960, many existed in the migrant areas of Haines City, but unapproved type privies have been eliminated there. Flush type facilities are in the process of being improved and brought up to population needs, especially in low-rent areas.

An example of the value of our sanitary survey in upgrading a neighborhood follows: A house in Eloise was found in an advanced stage of deterioration,

rat-ridden, with poor and mostly non-existent plumbing. The privy was about to overflow. The survey uncovered the situation.

A married couple and their children lived there, the couple having resided in resigned apathy for some 35 years.

A mutual agreement between the owner (a Massachusetts' resident) and the couple resulted in the premises being vacated with the house to be demolished as well as the privy.

We intend to increase our activities in the next year on rodent eradication and education toward that end. We realize that without educating the public on rodent control, eradication would be an impossibility.

Careful scrutiny has been and will continue to be given to the 13 migrant labor camps now existing in Polk County and to trailer or cabin areas that house migrant labor.

Apathy is one of the worst enemies. Through personal contact and through adroit educational programs, this enemy must be struck at continually. Some of this apathy has already be dissipated through months of concentrated effort. More effort must and will be made.

SERVICES PROVIDED

	Visits to Date
Public Water Systems	12
Private Water Plants	23
Private Sewerage Systems	8
Public Sewerage Systems	6
New Specification Privies installed	2
Garbage Disposal Systems	1
Percolation and Soil Log Test	1
Camps	46
Complaints Investigated	109
Nuisances Corrected	72
Rabies-Animal Bites	30
Eating and Drinking Establishments	204
Grocery & Meat Markets	110
Private Premises	217
Public Premises	36
Water Samples Collected	58
Rabies-Humans (Immunizations)	1

The present 13 labor camps in the county house approximately 1,750 migrants. There has been a distinct improvement noted in the sanitary conditions of the camps since the Project began. This may be credited to the fact that more time could be devoted to camp inspections due to an additional sanitarian being added to the staff under Project funds. This sanitarian was employed on December 1, 1964. Improvement was accomplished in general sanitation of the camps, although a good proportion of the sanitarian's time was spent on camp garbage disposal, sewage disposal and food handling.

Camp operators in this county have always seemed to have a penchant for using fifty-gallon oil drums as garbage and trash containers, instead of the regular 20 or 30 gallon capacity garbage cans. This created a fly problem, as there were no lids over the drums to prevent the entrance of flies. The camps are now using the accepted type garbage cans with lids and flies have been brought under control. The camps have their own garbage and trash pick-up service which is functioning well, although the health department keeps it under constant surveillance.

Many of the camps have central food service facilities which have been inspected and recommendations made and followed for the upgrading of these facilities. Improved food handling practices have been instituted to prevent any incidence of food-related illness in the camps.

Those camps depending on the sand filter method of sewage treatment have been advised to scrape away areas in the filters which have become clogged and consequently retard the efficiency of the filter's operation. This procedure was carried out on the complete filter beds at one camp, clogged sand being replaced by clean, fresh sand.

One camp water supply system, which produced a series of "unsatisfactory" water samples, was worked over until satisfactory samples were obtained. Water samples were taken regularly from all of the camps and tested in the laboratory for contamination.

Some structures in various camps were declared unfit for use and were replaced by the camp operators.

With the cooperation of the city building inspector of Haines City, major corrections in sanitary facilities for many bars, cares, restaurants and grocery stores patronized by migrants have been made during the last few months primarily in the Oakland and Hill (Negro) sections of Haines City.

Seven bars or eating places frequented by migrants have been brought up to sanitary standards.

One bar was cleaned up and an access walkway to the restrooms required to eliminate passage through the kitchen.

One bar was converted (by consent of the owner) to a beverage "take-out" and grocery store, as the bathroom facilities did not meet C.O.P. bar standards, while they did for a grocery.

In both of these instances, close cooperation between the sanitarian, the Beverage Department, and the Hotel and Restaurant Commission were needed to effect successful and mutually agreeable solutions. This same cooperation is resulting in a general urban upgrading, capping off the necessary and attendant strides in sanitation.

A café was allowed to close (agreeable to the proprietress) due to the apparent impossibility of keeping it a clean and orderly establishment.

In other bars, orders were given to clean up or improve sanitary facilities, with only one legal notice necessary.

One bar owner went several steps further beyond advised recommendations and completely remodeled the establishment.

One tumble-down grocery store in the Lakewood Park area that could not meet virtually any sanitary provisions was practically rebuilt to bring it up to health department standards.

One grocery store owner is rebuilding inadequate restrooms; one is closing rather than to remodel a hopeless building; one is closing but intends to reopen after extensive remodeling and one will remain partially open while revamping and remodeling.

In one one instance was it found necessary to issue a stop-sale order. This prevented the sale of 65 pounds of old and mouldy ham products. Several instances were found in which refrigerator temperatures were too high, and refrigerant repairmen were called to correct the situations.

Two groceries next to each other on 7th Street, Hill area, were found to be epitomes of neatness and other owners were directed to study these examples and emulate them.

In all cases, the sanitarian has found that use of precept and example to point out desired aims has proven psychologically effective and that good, clean American competition can accomplish much whenever appeals to integrity prove ineffective.

Additional Activities and Results

The several cases of condemned residential property torn down or to be torn down have been a project of the city building department, with the active encouragement of the Sanitation Department. In all instances in which businesses have closed, the impetus came from the city building inspector with backing from the Sanitation Department and at times from the Hotel and Restaurant Commission and/or the State Beverage Department.

The inspection of rooming and apartment houses has been a joint project of the Hotel and Restaurant Commission and the Sanitation Department. New and adequate restroom facilities, as well as a general cleanup and safety revamp were projects sparked by the Sanitation Department and brought to a successful conclusion. These facilities are heavily used, in season, by the migrants.

Regular school plant and cafeteria inspections were made on three Haines

city schools and an Eloise school attended by migrant students.

In short, a general upgrading of the migrant communities of Eloise, Hill, Oakland and Lakewood Park has been attempted and is still in progress.

Where there were inadequate restroom facilities or general insanitation, corrections have been made.

The rotten porches, ratty houses and mattresses or soiled bedding and generally insanitary conditions in the Ash and Cedar Street areas have been generally satisfactorily corrected -- several houses being entirely rebuilt.

Garbage and trash piles formerly found behind many houses in Eloise have now given way to neat lawns, but supervision is indicated.

Many septic tanks have been corrected and put in good order -- sometimes several at one time by a single landlord.

Much apathy has been overcome in the course of the sanitation work, eyes have been opened to sanitation needs on the part of the landlords, and on the part of a large number of our customary migrants.

Much more needs to be done -- mainly from an educational standpoint. These people are in crying need of health education. Perhaps the continual uprooting of their lives, the apathy of their temporary landlords, and the instability and insecurity of their way of life make for inborn sanitation problems.

Summary

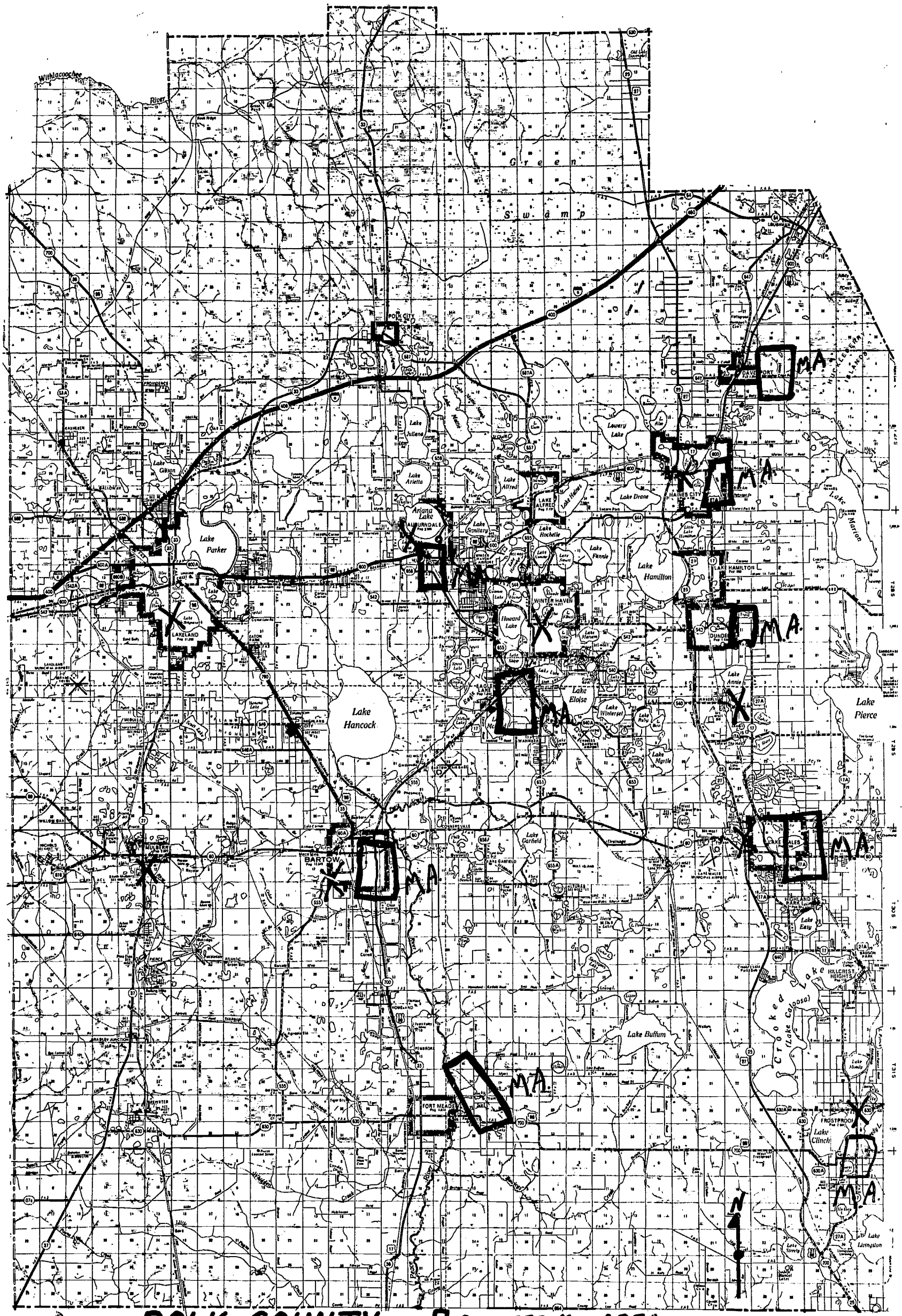
From the preceding reports it can be seen that we are looking at the difficulty of the migrant with broader views than simply the classical public health approach. This is necessary because there are many problems which are mainly of a moral, psychological, and economic nature.

Obviously, we haven't learned the answers, but they must be approached from two points: First, the parent who must be shown that self-help, that is,

initiative and hard steady work, will improve his situation. Second, the children must be educated, and even in some cases, educated to the degree that this education would clash with inherent beliefs of their parents.

The above statements are almost cliches, however, one concrete example of how the migrant and his family can be helped is through child-spacing or family planning. This may be where we should begin in a concentrated effort.

At any rate, the program has at least stimulated our thoughts regarding this unique segment of our population. It should be extended.


Withlacoochee River
Green Swamp
Lake Parker
Lake Hancock
Lake Hamilton
Lake Pierce
Lake Eloise
Lake Howard
Lake Juliana
Lake Gibson
Lake Arietta
Lake Ariana
Lake Alfred
Lake Rochelle
Lake Fannie
Lake Annie
Lake Easy
Lake Garfield
Lake Buffum
Lake Marion
Crooked Lake (Lake Caloosa)
Lake Clinch
Lake Livingston
Lake Nuttle
Lake Winterset
Lake Lowery
Lake Drane
Lake Haines
Lake Sanitary
LAKELAND
WINTER HAVEN
BARTOW
AUBURNDALE
LAKE ALFRED
LAKE HAMILTON
HAINES CITY
DAVENPORT
FROSTPROOF
FORT MEADE
POLK CITY
MA
X
N
POLK COUNTY
4 MILES
DENOTES MIG. AREA
X DENOTES CLINIC

Although the value of immunizations is stressed by health departments, many migrant children never complete theirs due to parents' apathy.

Mothers wait for services at one of Polk County's nine health centers. Migrant population of 22,000 strains facilities part of the year.

Clinic physician is sought out sometimes by migrant parents after home remedies, and occult practices have failed to cure an ill child.

Health departments dentist finds many cavities in migrants' teeth. Emergency extractions are frequent.

PUTNAM, FLAGLER COUNTY HEALTH DEPARTMENTS

James R. Sayers, M.D., Director

Area of Putnam County: 803 sq. mi.

Resident Population: 33,000

Number of Migrants: 3,000

Area of Flagler County: 483 sq. mi.

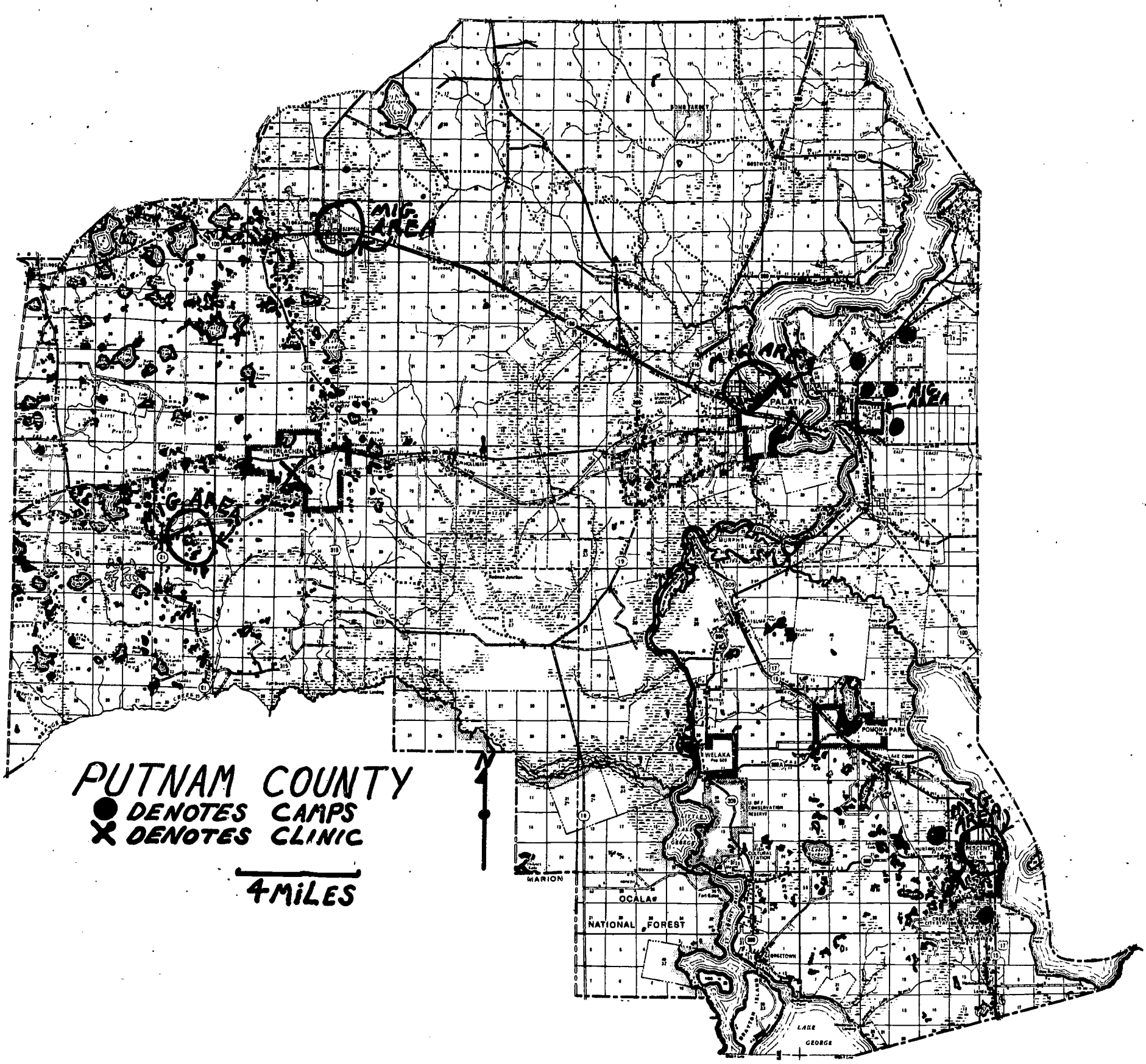
Resident Population: 5,300

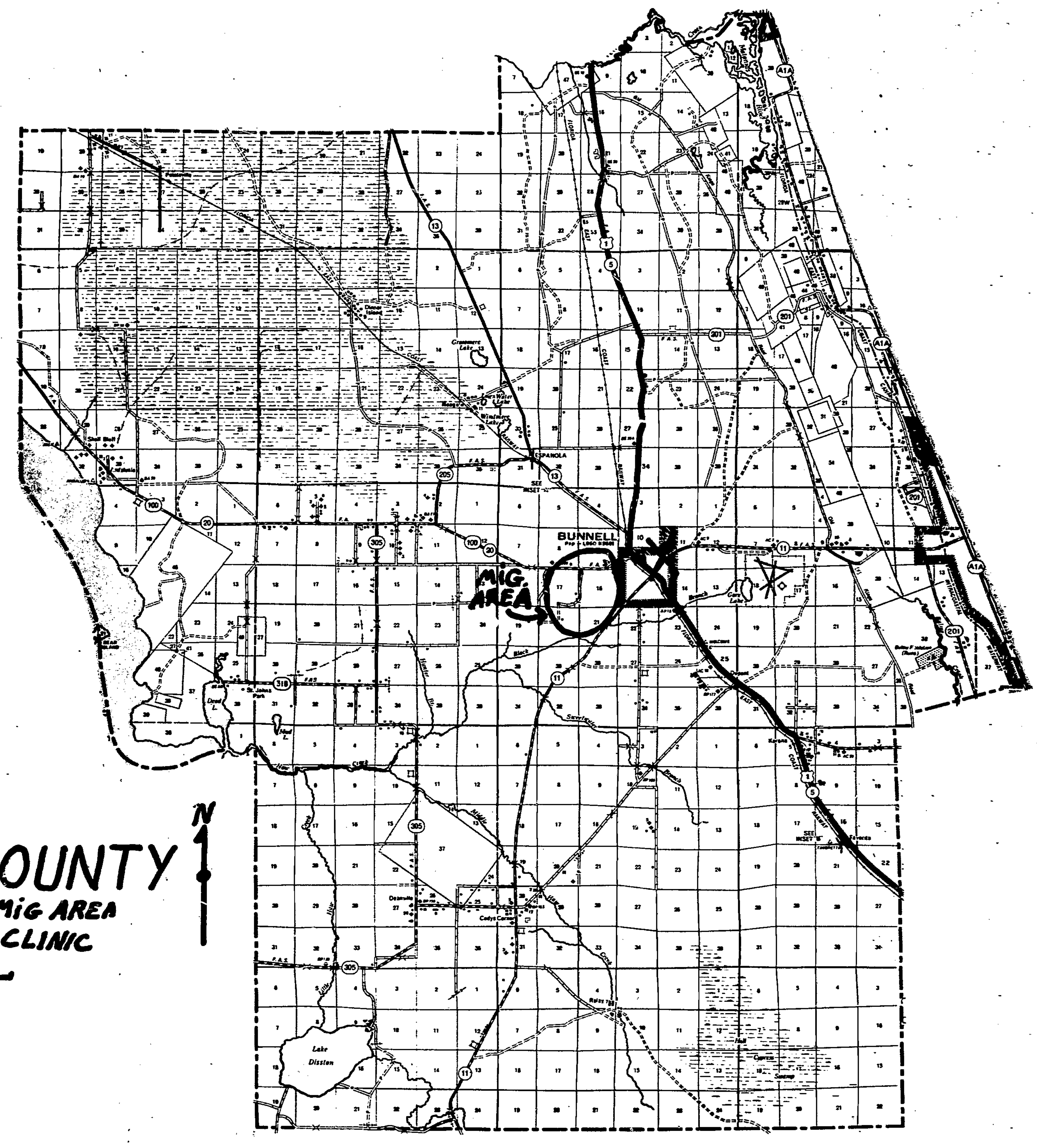
Number of Migrants: 750

Migrant Project Staff: 1 Public Health Nurse
1 Clerk-Typist (part-time)

PUTNAM AND FLAGLER COUNTIES

As of May 31 of this year, neither of the two Project Staff positions had been filled, due to absence of employment clearance from State agencies. The required clearance should be forthcoming in the near future.


PUTNAM COUNTY
DENOTES CAMPS
DENOTES CLINIC
4 MILES
N
PALATKA
INTERLACHEN
WELAKA
POMONA PARK
MARION
OCALA
NATIONAL FOREST
LAKE GEORGE
CRESCENT CITY
BOSTWICK
BOMB TARGET



FLAGLER COUNTY

O DENOTES MIG AREA
X DENOTES CLINIC

4 MILES

SARASOTA COUNTY HEALTH DEPARTMENT

Richard H. Veldhouse, M.D., Director

Area of County: 586 sq. mi.

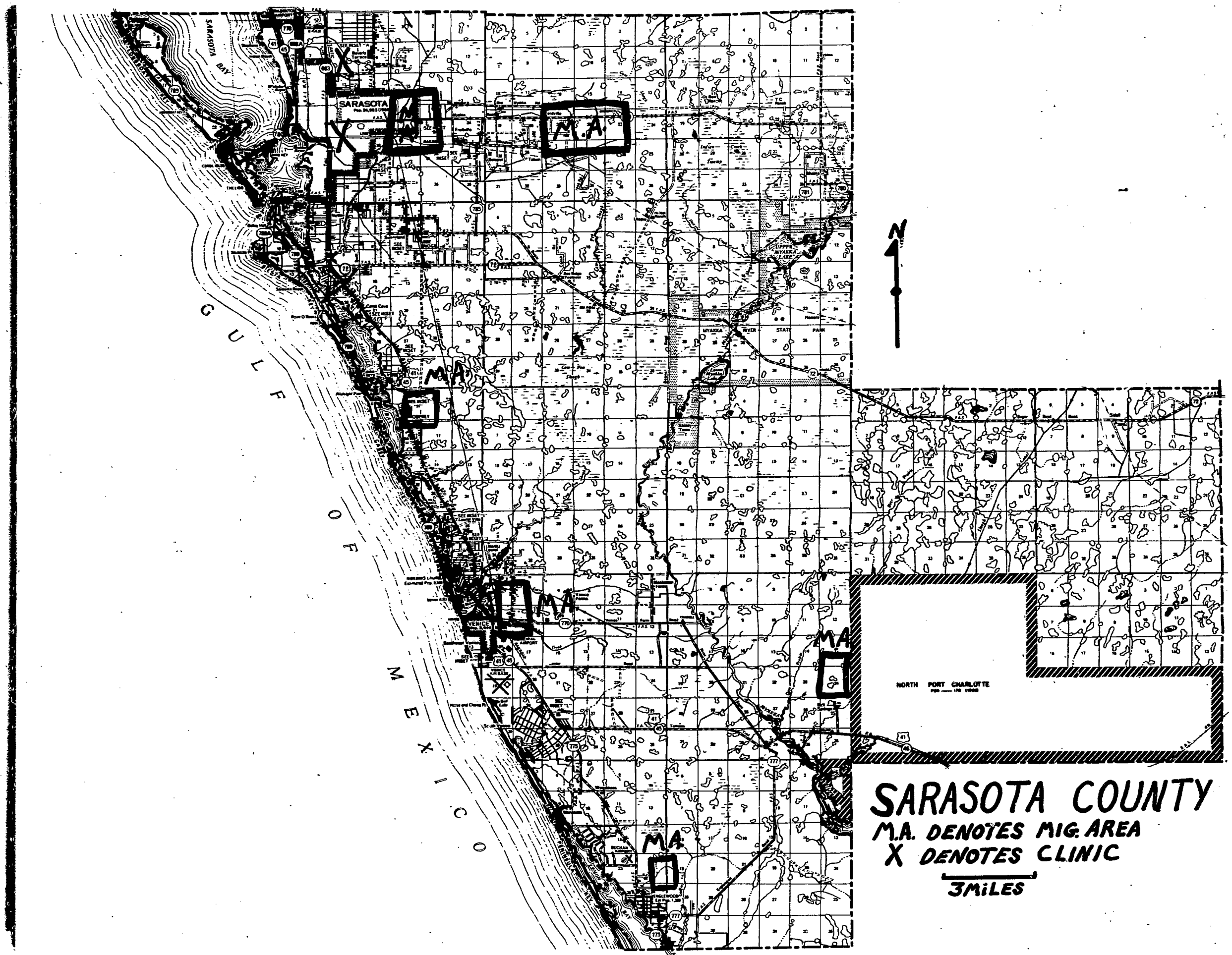
Resident Population: 95,000

Number of Migrants: 4,500

Migrant Project Staff: 1 Public Health Nurse
1 Sanitarian
1 Clerk-Typist (Part-Time)

SARASOTA COUNTY

As of May 31 of this year, no member of the Project Staff had been hired, due to absence of employment clearance from State agencies. The required clearance should be forthcoming in the near future.


SARASOTA BAY
GULF OF MEXICO
SARASOTA
VENICE
NORTH PORT CHARLOTTE
MYAKKA RIVER STATE PARK
UPPER MYAKKA LAKE
LOWER MYAKKA LAKE
M.A
M.A
M.A
M.A
M.A
X
X
N
SARASOTA COUNTY
M.A. DENOTES MIG. AREA
X DENOTES CLINIC
3MILES

AGENCY COOPERATION

It would be well nigh impossible to list the seemingly myriad groups, organizations and agencies which have been involved with us either directly or indirectly in the Migrant Program during the past season. Certainly, we could not have received better cooperation from the Farm Labor Representatives of the State Employment Service, County Agricultural Agents, the Florida Christian Migrant Ministry, State and County Welfare Agencies, State Beverage Department and the State Hotel and Restaurant Commission.

Poverty Program officials, school officials, city and county officers and a veritable host of others were all asked for assistance in one way or another to help smooth the path of the Project during the first year of our "action" program. All were most cooperative. Both the Dade and Palm Beach County Health Departments divulged information on procedures which will assist us in solving some of the problems that presently beset us.

Finally, an accolade should go to the United States Public Health Service, the agency that made our Project possible. Their cooperation has been excellent.

FUTURE PLANS

Although Robert Burns wrote: "The best laid schemes o' mice an' men gang aft a-gley", we face the future with an optimistic outlook, as far as the Migrant Program is concerned. The Project has been in operation for nine months and has seven more months to run before a new Project year begins. During these nine months, the Project Objectives have been quite substantially met. Much migrant housing has been upgraded, the health of some of our target population has been improved, increased interest in migrants has been evinced by the general public. Health department personnel have come to realize that the migrant problem is greater than they realized. All of this is to the good, and we are gratified with the progress made, but we have no intention of resting on these laurels. There are still problems to be overcome to streamline the program and to make it more efficient, effective, and far-reaching.

During the remainder of the Project year, there will be increased emphasis by the sanitarians on improving migrant living conditions. This will include not only camp and urban housing, but the provision of those facilities necessary for improved field sanitation. Nurses and health educators will endeavor to contact people who can serve as volunteer helpers in clinics and/or provide transportation to migrants who otherwise may not be able to seek service at clinics or private physicians' offices. The number of day and evening clinics for migrants will be increased. All Project personnel will be encouraged to avail themselves of every opportunity to attend meetings of groups and organizations for the purpose of acquainting the members with the Project's aims and reason for being. Increased publicity for the Project and for the migrants' problems in general will be stressed on both the local and State level. Additional counties will be approached to participate in the Health Service Referral System and in the Migrant Project. Closer cooperation with other agencies and programs involved either directly or indirectly with migrants is planned. More personnel working in counties with appreciable numbers of Spanish-speaking

migrants will be encouraged to become more familiar with this language. All Project personnel will be expected to raise the present amount of health education aimed at migrants to new levels. All migrants who visit clinics will be given personal health records. Finally, all Project personnel and others in health departments who are also working with migrants will receive information, both printed and oral, dealing with all facets of the migrant's life. These will include wages, transportation, culture of ethnic groups, conditions in other states (housing, medical care available, etc.), hiring practices, and other pertinent items. It is felt that if the personnel in health departments acquire an insight into and a knowledge of the population with whom they work, they will, in consequence, be better prepared to perform their functions and to spread the word to the general public.

The foregoing plans may appear to be an overly-ambitious undertaking, but we subscribe to the adage "Nothing ventured, nothing gained". The only foreseeable obstacle to bringing our plans to fruition is the factor of time and only time will tell whether or not we can accomplish what we are setting out to do.

Project Objectives for the coming Project year are as follows:

1. To work more closely with Project counties in the technical aspects of the migrant health service program as it concerns medical care.
2. To continue to provide opportunity for state and local public health officials and others to evaluate the program for migrants and to plan for its improvement.
3. To continue to improve the environmental health aspects of the migrants' existence.
   a. Through stricter enforcement of the Camp Regulations,
   b. Through encouragement of growers to provide field sanitation facilities.
4. To develop, utilize, and revise when advisable, a uniform system of forms and records for all Project counties.

5. To test a procedure for extending health education to migrants and compiling information on the migrant population through the use of liaison workers.
6. To continue to inform the general public and certain groups of the Project's aims and the migrants' problems.
7. To involve additional counties in participating in both the Health Service Referral Form System and in the Migrant Project.
8. To revise the Referral System where necessary and encourage its use both within and outside the State.
9. To offer more comprehensive medical treatment to migrants in Alachua, Broward, Collier, Flagler, Glades, Hendry, Highlands, Hillsborough, Lee, Orange, Polk, Putnam, and Seminole Counties.
   a. Through employment of staff physicians to serve as clinicians.
   b. Through referral to private physicians on a fee-for-service per patient basis.
   c. Through employment on a per-clinic session basis (contract) of local physicians to serve as clinicians.
10. To offer specified types of dental services (especially emergency) to migrants in Collier, Flagler, Glades, Hendry, Highlands, Hillsborough, Lee, Putnam, and Seminole Counties by referral to private dentists on a fee-for-service basis.
11. To help solve the migrants' problem of transportation.
   a. Through the use of a mobile clinic in Alachua, Broward, Hillsborough and Seminole Counties.
   b. Be reimbursement at a specified rate per mile to drivers to transport patients to clinics and offices both in and outside Glades, Hendry, and Highlands Counties.
12. To cooperate more closely on the State and local level with any and all groups, agencies, and programs involved in working for the betterment of the migrants' lot.

In closing this section of the Report, it might be of interest to mention that the September issue of Florida Health Notes, a monthly publication of the Florida State Board of Health with wide distribution, will be devoted to migrant labor and the Migrant Project.

Project Grant Number: Mg-18B R (65)

Project Title: A project to develop a basic statewide program of health services for migrant farm workers and their dependents in Florida

Period Covered: September 1, 1964 through May 31, 1965

SUMMARY

The first "action" year of the Florida "State" Migrant Health Project began in September 1964 with ten counties participating and will end in December 1965 with thirteen (13) counties included. The period covered in this Annual Progress Report was an eventful one for migrants and public health personnel alike.

Due to the unusually favorable weather conditions, bumper harvests of both fruit and vegetables were experienced. Some labor shortages developed and there was a shortage of housing for migrants in some areas. This housing shortage necessitated a less intensive enforcement of housing regulations in some areas in order that the migrants would have some shelter however unsatisfactory it might be. A number of new camps were constructed and many old ones were condemned. Some counties and growers expressed interest in obtaining Federal loans to construct needed housing for migrants.

The recent trend of migrants moving into urban areas from the more isolated labor camps continued. This movement has created problems for the residents and public officials. It has also created problems for various disciplines of public health personnel. With the migrants congregated in camps, the sanitarians can better control sanitary conditions under which migrants live, nurses can make more home visits, health educators have practically a captive audience and field clinics can be set up with the assurance that patients will attend and that these patients will be migrants.

(Summary - MG-18B R (65))

When migrants move into communities, as they are now doing, the whole picture changes. The sanitarian loses control of the group and, consequently, their environment. He must spend time searching the migrants out or conducting lengthy sanitary surveys of neighborhoods to spot the migrants' locations. He has to deal not with one camp operator, but with a number of landlords. The same problems are faced by the nurse who has to identify first, who is a migrant and who is not and then spread her home nursing visits over a wider area. The health educator and the physician must restrict their direct activities with migrants to the health department clinic. All of these problems have been encountered this past season and there appears to be no easy way of combating them as long as the migrants drift cityward. Should this trend continue, the health personnel will be required to develop unique methods of working with the "urban migrant", previously a limited segment of the total group. It is felt that if plans do materialize for the employment of liaison workers to assist in identifying migrants, some of the problems related to the "urban migrants" will be lessened.

The ever-present language barrier is being partially overcome, at least by those personnel with enough interest to familiarize themselves with the Spanish language. More personnel will be encouraged to follow in their footsteps this fall and during 1966. The language barrier has long been a major problem for public health personnel who need to communicate with migrants in those counties having appreciable numbers of Spanish speaking migrants.

Among other problems that have arisen since the Project's inception is the curtailment of desired services due to seemingly inadequate travel allotment to certain counties. The only solution to this problem is to request

higher travel allotments in the future to assure that Project personnel will be able to carry on their duties more completely.

Another problem was the inability to attract qualified personnel to enter the migrant program and once in, to retain their services. This problem will apparently be resolved in the near future when a general raise in salary scales will go into effect for public health personnel. This should result in more nurses and sanitarians being drawn to Florida and in discouraging present Project personnel from seeking employment outside the Project in particular, and the field of public health in general.

Personnel in Project counties have come to realize that there is a great deal that they do not know about migrants. They realize that to do a better job they must know the group with whom they are working. To fill this void, it is proposed that an in-service training program of sorts be initiated to familiarize public health personnel with various facets of the migrants' existence.

The Project personnel have also realized that the migrant problem is one of much greater proportions than they believed possible at the beginning of the past season. Now they wish to step up their services to migrants to meet at least some of the more conspicuous needs. This is especially true as far as nursing, medical and sanitation services are concerned. All agree that more was accomplished in the months of the Project's life than in years of previous work, but none are satisfied to stop there. More personnel are requested, more clinic sessions are recommended, more funds are needed for physicians' and dentists' services. One county is reactivating an unused mobile clinic, others are establishing new field clinics or refurbishing existing ones.

(Summary - MG-18B R (65))

Dissatisfaction has been expressed at the lack of a uniform record and form system for migrant activities. This will be solved in the near future with the development of forms and records to be used in all Project counties.

The Health Service Index and Referral Form System has enjoyed a productive year and is evidently growing in popularity both within and outside the State. Eight additional counties are now participating, bringing the total to twenty-two and more are expected to join. Several other states have also signified their intention of joining Florida, New York, Virginia, Delaware, and South Carolina in the System. Changes in the Referral Forms are being considered to make them more complete.

There was a resurgence of interest in migrants on the part of the general public this year and it is planned to keep this interest stimulated. Project personnel will be expected to inform the public at every opportunity regarding the aims and worth of the migrant program and the need for the public's assistance in furthering these aims. The September issue of Florida Health Notes, a monthly publication of the Florida State Board of Health with wide distribution, will be devoted to migrants and the Migrant Project.

All of the Project Objectives have been substantially met during the first nine months of operation. It was found necessary to reduce the number of health education pamphlets planned from fifteen to ten due to the unexpected high expense of developing each pamphlet and the lengthy procedure involved.

Lee County physicians would not staff an evening field clinic so the director of the health department expects to employ a physician part-time to overcome this obstacle. In Glades and Hendry Counties the clinician never did

appear, although he kept these health departments dangling for six months. Another clinician will be employed in July which will enable the program in these counties to go forward at an accelerated pace.

Objectives proposed for the next Project year are greater in scope than those followed in this year's program and reflect the desires of the various county health department directors to render more services, especially dental and medical, to the target population.

The directors feel that the program has been effective so far, that it should be broadened and that it should be continued. The decrease in migrant hospital admissions and in the infant mortality rate, plus the increase in the number of migrants receiving services this year tends to bear out their opinions on this score. As one Project county public health nurse stated in discussing the Project's worth: "The greatest accomplishment has been to be able to give some service to every person visiting the department." This is a simple but significant statement and all of us in Florida who work with migrants add "Amen."